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MAINLAND CHINESE LAY BELIEFS ABOUT PSYCHOLOGICAL PROBLEMS: AN EXAMINATION OF BELIEFS ABOUT CAUSES AND CURES

BY

DAVID BYRON SINCALIR

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE DEGREE

OF MASTER OF EDUCATION

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1994

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DEGREE FOR WHICH THESIS WAS PRESENTED: M. Ed.

YEAR THIS DEGREE WAS GRANTED: 1994

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Committee member: Dr. J. G. Patterson

External examiner: Dr. M. F. Juliebo

Dated: Sept 01/1994

To my family

Abstract

This study replicated Luk and Bond (1992) concerning the heuristic value of Winer's (1980) attributional framework in relation to Hong Kong lay people. In addition, the study extended Luk and Bond (1992) to include a population of Chinese from the People's Republic of China residing in Edmonton and five additional disorders of childhood. In this descriptive study, subjects, 112 ethnic Chinese individuals from the People's Republic of China, rated the importance of 26 causal attributions and 36 curative attributions in relation to 15 psychological or behavioural problems. The problems examined were: (antisocial problems) child abuse, compulsive gambling, lack of civic responsibility, social apathy and using the back door (corruption); (adult pathological) agoraphobia, anorexia nervosa, neurasthenia, schizophrenia and shen-kuei syndrome; (child pathological) ADHD, autistic disorder, conduct disorder, learning disability and mental retardation. Results indicated that subjects held a primarily interactional view of the causes and cures of the pathological problems, rating both internal and external attributions as important. With regard to antisocial problems, subjects perceived primarily external (social) causal attributions as important, but rated internal (self control) attributions as most important in overcoming such difficulties. A panel of expert judges evaluated each of the causal and curative attributions in relation to Weiner's attributional framework involving locus, stability and controllability. There was agreement on less than 20 percent of the attributions with respect to all three dimensions of Weiner's framework. Discussion focuses on the nature of mainland Chinese lay beliefs and the implications of these beliefs for help seeking behaviour among this population.

Acknowledgements

The author wishes to express sincere thanks to Dr. Bruce Bain, the supervisor of this thesis for his never ending patients, encouragement and nurturance.

Sincere appreciation is also extended to Dr. H. Janzen and Dr. J. Patterson, committee members, for their time, their thoughtful input and interest in my work.

A debt of gratitude is also owed to the following persons:

Dr. C. Hoffman, for all of his help in the production of this thesis.

Cui Xin-Jie (Cindy) who assisted with the translation work and distributions.

Olive Triska for all her assistance as statistical consultant.

And to the remaining people who served as expert judges: Dr. W. Hague, Tatia Lee and Michelle Worht.

My many friends who also helped in the distribution and collection of questionnaires.

And particularly the members of the Chinese Students and Scholars Association, their families and friends who participated in the research, and without whom this study would not have been possible.

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CHAPTER I

Introduction

Background to the study

There is a growing consensus among some researchers that Western psychological constructs are of questionable validity when applied in other cultural contexts (Ponterotto & Casas, 1991). Since the mid 1950's there has been a burgeoning interest in the study of cultures' effects on various aspects of human psychology. One of the assumptions underlying this approach to psychological research is that beliefs inculcated in disparate cultures result in culture-specific variations in human behaviour. While there have been numerous studies addressing the role of beliefs in relation to psychological and behavioural problems, there is a paucity of research about the beliefs of contemporary mainland Chinese in this regard. Since the mainland Chinese make up approximately one fourth of the world's population, this lack of research constitutes a significant deficit in the existing body of cross-cultural psychological knowledge.

Culture exerts a potent influence in shaping beliefs. The beliefs that people hold significantly influence their behaviour. The effect of culturally transmitted beliefs on behaviour is very apparent in the area of mental health. Divergent belief systems, or world views, influence peoples' attitudes toward individuals with psychological problems (Bhugra, 1989; Nieradzik & Cochrane, 1985; Nunnally, 1961; Purvis, Bryande, Rouse, Vera & Range, 1988), and the way in which individuals recognise, label and seek help for psychological problems (Angel & Thoits, 1987; Cheung, 1986; Cheung, 1987;

Christensen, 1987; Hall & Tucker, 1985; Ip, 1985; Lin, Inui, Kleinman, & Womack, 1982; Narikiyo & Kameoka, 1992; Tracey, Leong & Glidden, 1986; Ying, 1990). Culturally transmitted beliefs also influence responses to different types of psychological interventions (Flaskerud & Liu, 1991; Fuller, 1986; Kleinman, 1988; Sue, Fujino, Hu, Takeuchi & Zane, 1991) and, in some cases, the course and the long-term outcome of these problems (Kleinman, 1986, Waxler, 1979).

It has been suggested that the efficacy of mental health interventions, that the client will "accept the diagnosis, remain in treatment, and, finally recover" (Ying, 1990, p. 394), is dependent on a match between the 'explanatory model of illness' (EM) of the client and that of the clinician (Kleinman, 1980; Sue, 1978). The explanatory model of illness subsumes features such as beliefs about the nature, causes and cures of disorder.

One approach to understanding the client's explanatory model of illness suggested by Kleinman (1980) requires that therapists explicitly explore this dimension with clients and their families. This approach is a necessary aspect of the therapeutic relationship in order to avoid the tendency toward treating clients stereotypically with respect to culture. However, it is advantageous for the therapist to have an understanding of the general structure of the client's cultural beliefs as a basis from which to start the exploratory process, and to initially bridge the cultural gap that may exist between counsellor and client (Sue & Sue, 1977). The current research attempts to examine and describe the beliefs of mainland Chinese people about the causes and cures of a variety of psychological and behavioural problems. The purpose of the research was to provide a

better understanding of the explanatory model of this population with regard to these problems.

Significance of the study

The ethnic composition of Canada's population is changing. Within the last several decades there has been a significant shift in Canadian immigration patterns. Prior to the end of World War II immigrants came primarily from the countries of Europe. In the years since the war a significant proportion of Canada's immigrants have come from the countries of the third world. This trend portends major changes in the cultural composition of the Canadian population (Driedger, 1989).

The number of ethnic Chinese residing in Canada nearly doubled in the years from 1971 to 1981 (Driedger, 1989). In 1986 in Canada, the immigrant population (by place of birth) of Chinese from the People's Republic of China (PRC) numbered 119,190 individuals (Statistics Canada, 1989). By 1991, that number had risen to 157,405 (Statistics Canada, 1992). This represents a 32 percent increase in this population in five years. Over this period the proportion of immigrants from mainland China rose from 3 percent to 3.6 percent of the total immigrant population in Canada (Statistics Canada, 1992). This is an increase of 20 percent.

The figures for the province of Alberta showed a lower overall increase than that found in the country as a whole. However, in the five year period from 1986 to 1991 the province recorded an increase of 22 percent in the number of Chinese immigrants from the People's Republic (Statistics Canada, 1989; Statistics Canada, 1992). These figures reflect

only the numbers of first generation immigrants. Their offspring, born in Canada, will further inflate the number of individuals who will share, to a greater or lesser extent, a cultural heritage derived from the milieu of the People's Republic of China. As China continues to become increasingly affluent and open to the rest of the world, and the Chinese population becomes more cosmopolitan, the number of people able to immigrate to Canada is more likely to increase than to decrease.

Figures for the University of Alberta show a very dramatic increase in the population of full-time students from the People's Republic of China. In 1984, there were 6 students classified as permanent residents and 41 student visitors from the PRC (Office of the Registrar, 1984). Ten years later, in 1994, the numbers had increased to 174 and 177 respectively (Office of the Registrar, 1994). This represents an increase of 2800 percent in permanent residents and 332 percent for student visitors studying full-time at the University of Alberta.

Considering the influence of culturally shaped beliefs on responses to psychological problems (vis-à-vis identification and help-seeking behaviour) and on the efficacy of interventions used to ameliorate such difficulties, it is imperative that the mental health community gain a better understanding of the nature of these beliefs. This understanding will help mental health professionals to better target and design interventions to serve this growing population in more culturally appropriate and efficient ways.

Purpose of the study

This research was intended to measure mainland Chinese lay beliefs about the causes and cures of selected psychological and behavioural problems. The primary objective was to provide a description of the degree of importance that lay people from mainland China attach to various attributions about the causes and cures of 15 different psychological and behavioural problems. Concomitantly, the study was intended to determine if mainland Chinese differentially apportion importance to the various attributions of causes and cures according to the particular problem being considered. The second objective of the study was to compare the results observed with this population with those of studies conducted with similar groups in Hong Kong and Great Britain. The third objective in conducting the study was to describe the attributions in terms of attribution theory, specifically, in relation to Weiner's (1980) attributional framework. This analysis was intended to ground the results of the study in a theoretical framework regarding the sources of motivation. The results are discussed in relation to research findings about help-seeking behaviour and the efficacy of particular psychological intervention strategies.

Definition of Terms

For the purposes of this study definitions of terms are as follows:

Lay beliefs: Luk and Bond (1992) define lay theories as: "The explanations that typical members of a culture give for particular social behaviors and events". In the context of this study, lay beliefs are defined as the rationalisations that non-experts use to associate particular causes with events or phenomena.

Mainland Chinese: Individuals born and acculturated in The People's Republic of China (PRC), who's cultural experience derives from the milieu shaped by Chinese history both prior to and since the advent of the People's Republic.

Neurasthenia: This is a psychosomatic syndrome first described by Beard (1869) and exported to China with the advent of Western psychiatry in the early 1900's (Kleinman, 1986). It is characterised by "bodily weakness, fatigue, tiredness, headaches, dizziness, and a range of gastrointestinal and other complaints" (Kleinman, 1986, p. 23). In his study of the disorder at the Hunan Medical College, Kleinman (1986) reported that neruasthenia was the most prevalent diagnosis given by Chinese psychiatrists and that using Western diagnostic criteria of the American Psychiatric Association, the Diagnostic and statistical manual of mental disorders, third edition (1980), roughly 86 percent of these cases could be re-diagnosed as suffering from some form of anxiety or depressive state.

Shen-Kuei syndrome: The DSM-IV (1994) defines Shen-kuei, a culture-bound, syndrome as:

> A Chinese folk label describing marked anxiety or panic symptoms with accompanying somatic complaints for which no physical cause can be demonstrated. Symptoms include dizziness, backache, fatigability, general weakness, insomnia, frequent dreams, and complaints of sexual dysfunction (such as premature ejaculation and impotence). Symptoms are attributed to excessive semen loss from frequent intercourse, masturbation, nocturnal emission, or passing of 'white turbid urine' believed to contain semen.

> Excessive semen loss is feared because of the belief that it represents the loss of one's vital essence and can thereby be life threatening. (p. 848)

(Note: This definition was originally authored by Wen & Wang (1981, p. 357)).

Organisation of the Thesis

Chapter I consists of the introduction, describing the background, significance, and purpose of the study, as well as the definitions of some of the key terms used in the study. This is followed in Chapter II by a review of the literature, including a description, and the development of Weiner's attributional framework. This Chapter also includes a review of the literature on beliefs about the causes and cures of psychological and behavioural problems, and some studies on help-seeking behaviour in Asian populations. Chapter III describes the research design, including a description of the sample, the instruments, the data analysis and some of the limitations of the study. Chapter IV provides a description of the results of the study. A discussion of the results, the conclusion and a discussion of the implications for practice and future research comprise Chapter V.

Chapter II

Review of the Literature

Weiner's Attributional Framework[1]

Attribution theory is primarily concerned with the way that people use information to construct causal theories to explain their own behaviour, the behaviour of others and events that occur in the social environment. People undertake causal searches to enable them to more accurately anticipate the future and control events in their lives (Fiske & Taylor, 1991). Much of the work on attribution theory has focused on the way in which people use information to make judgements about others. The American psychologist Bernard Weiner, a highly influential figure in the area of attribution theory, was one of the first theorists to make the individual the unit of analysis. That is, his research focused on how the individual uses information to arrive at causal judgements in relation to his or her self. Weiner's work was primarily concerned with attributions about success and failure, and how such attributions influenced affect, motivation and future performance in achievement oriented contexts. His intention was to define the link between antecedent causes, the intervening cognitive processes and subsequent action.

The general principle underlying his model is that "beliefs about the causes of success and failure mediate between antecedent stimulus-organism transactions and ensuing achievement behavior" (Weiner, Frieze, Kukla, Reed, Rest & Rosenbaum, 1972,

---

[1] This discussion will present the rational underpinnings of Weiner's attributional framework. For a well rounded and current examination of the empirical literature see Fiske and Taylor (1991). Weiner (1980) provides a thorough review of the earlier empirical studies relating to attribuiton theory.

p.96). Weiner (1979) reasoned that when confronted with a particular outcome, people follow a definable evaluative sequence. In doing so, they assess particular categories of information in deciding about causality, and these decisions influence later behaviour in similar situations.

Expanding on the work of Heider (1958) and Rotter (1966), Weiner (1980) constructed a taxonomy distinguishing the principle dimensions along which the information used to form attributions about causality is arrayed, and linked attributions to various affective and behavioural responses. Heider (1958) had earlier made a distinction between two causal loci. "In common-sense psychology (as in scientific psychology) the result of an action is felt to depend on two sets of conditions, namely, factors within the person and factors within the environment" (Heider, 1958, p. 82, as cited in Weiner, 1985a). This placed the location of the impetus for action either within the person or in his or her environment.

Rotter (1966) later applied the dimension of locus (of control) to the categorisation of the actor. Thus, people were classified as being either internal or external with respect to their tendency to ascribe the causes of various events in their lives. This tendency to attribute causality to internal or external factors was thought to influence the individual's social perception and behaviour. Internals were thought to possess a heightened sense of personal efficacy and were strongly motivated to take initiative in determining outcomes. Conversely, Externals perceived outcomes as determined by the caprice of outside forces and were passive in their approach to life (Fiske & Taylor, 1991). Weiner et al. (1972) concluded that the internal-external dimension, as posited by Rotter, lacked explanatory

power; "Rotter and his colleagues gave insufficient attention to the richness of causal explanation and confounded dimensions of causality" (Weiner, 1985a, p. 556). Weiner felt that there was another, more fundamental, attributional dimension that influenced decisions about 'causality'.

Again, using the work of Heider (1958) as a starting point, Weiner and his colleagues hypothesised that "in attempting to explain the prior [and predict the future] success or failure at an achievement related event, the individual assesses his or her level of ability, the amount of effort that was expended, the difficulty of the task, and the magnitude and direction of experienced luck" (Weiner, et al. 1972, p.96). This group of factors formed the conceptual basis for the first two dimensions composing Weiner's attributional framework, locus and stability. In terms of the locus dimension, ability and effort were categorised as internal attributions, while task difficulty and luck were conceptualised as external. On the stability continuum, ability and task difficulty reflected stable attributions, while effort and luck occupied the opposite, unstable, end.

In Weiner's framework, stability attributions replaced locus as the most important dimension in predicting future performance. Where a person has experienced failure, attributions to stable causes such as lack of ability or task difficulty were thought to diminish motivation to perform in similar tasks in the future, whereas attributions to unstable causes (effort or luck) would not produce this decremental effect on motivation. Attributions regarding locus, on the other hand, were thought to influence the individual's sense of self esteem. Attributions of failure to internal causes (ability or effort) were thought to diminish self esteem, and those made to external causes (luck or task difficulty)

left self esteem relatively unaffected (Weiner et al. 1972). While these dimensions were perceived as a more complete delineation of the attributional process, than that provided by locus alone, Weiner felt that the model was still incomplete.

Weiner and his associate Robert Rosenbaum (1972, as cited in Weiner, 1985a) reasoned that within the dimensions of locus and stability, some of the causes of behaviour were under the volitional control of the actor and some were not. "Mood, fatigue and temporary effort, for example, all are internal and unstable causes. Yet they are distinguishable in that effort is subject to volitional control. This is not typically true of mood or the onset of fatigue, which under most circumstances cannot be willed to change" (Weiner, 1985a, p. 551). They concluded that this reasoning could be applied to causes on both the stability and locus dimensions. The three final dimensions that constitute Weiner's attributional framework were thus:

- Stability: The degree to which a cause is perceived to persist over time or across situations.
- Locus: The degree to which a cause is perceived to be internal or external to the individual.
- Controllability: The degree to which a cause is perceived to be under the volitional control of the individual.

There is a substantial number of empirical studies in achievement related contexts that supports the validity of the three dimensional structure defined by Weiner (see for example, Meyer, 1980; Meyer & Koelbl, 1982). Table 1 presents the three dimensions of

Weiner's attributional framework as they might be applied to assessing success or failure in an academic context.

Table 1: Causes of Success and Failure, Classified According to Locus, Stability, and Controllability

	Internal		External	
Controllability	Stable	Unstable	Stable	Unstable
Uncontrollable	Ability	Mood	Task difficulty	Luck
Controllable	Typical effort	Immediate effort	Teacher bias	Unusual help from others

Note. From "A Theory of Motivation for Some Classroom Experiences" by B. Weiner, 1979, Journal of Educational Psychology, 71, p. 7. Copyright 1979 by the American Psychological Association. Reprinted with permission.

In this way Weiner and his associates constructed a framework for understanding and categorising the types of information that lay individuals use to interpret causality in the personal and social worlds. Weiner next addressed the way in which the attributions that people made about causality influenced motivation in achievement related contexts.

After people experience a particular outcome Weiner (1985a) posits that they go through a temporal sequence of events in response to that outcome (see Figure 1). Following an outcome (success or failure) there is an initial emotional response depending on the nature of the outcome. This emotional response precipitates an attributional search. Between attributions and action are the various affective consequences and the variable of expectancy which governs motivation to act (Weiner, 1985a).

Individuals in achievement related pursuits expect either a positive (success) or negative (failure) outcome. Their expectancy for a particular outcome is determined by past experience in similar situations or on social comparison (i.e., the belief or knowledge

that others in similar situations normally succeed or fail) (Fiske & Taylor, 1991). These expectancies are influenced by the attributions made in relation to the situation. For example, if the individual's attributions lead him or her to hold a positive outcome expectancy (e.g., success is expected) than this is thought to increase the motivation to act. However, if the expected outcome is negative (e.g., failure is expected) the motivation to act is reduced. Therefore, high expectancy is related to increased motivation to act, and low expectancy is related to decreased motivation to act (Weiner, 1985b).

Weiner (1985a) indicates that "stable, relative to unstable, ascriptions are related to high expectancies of success after goal attainment and to low expectancies of success after a failure" (p. 557). Thus, in Weiner's model, attributions about the stability of causal factors are the primary determinants of outcome expectancy. Likewise, the model predicts that attributions regarding locus principally influence self-esteem, and those addressing controllability influence emotions such as shame, guilt, anger, gratitude and pity.

Figure 1 depicts the total attributional process, from the antecedent outcome to behavioural consequences. Within this model, links 6 through 10 are of particular interest in the present context. First, the notion that causal attributions about stability (link 6), mediate expectancy to produce (link 8) either hopefulness (enhancing motivation to act) or hopelessness (which inhibits goal-directed activity) have logical consequences in the current study. By extension, if psychological or behavioural problems are attributed to stable causes, the result could be perception of hopelessness which would conceivably diminish the motivation to seek help. However, if the cause of these types of problems is

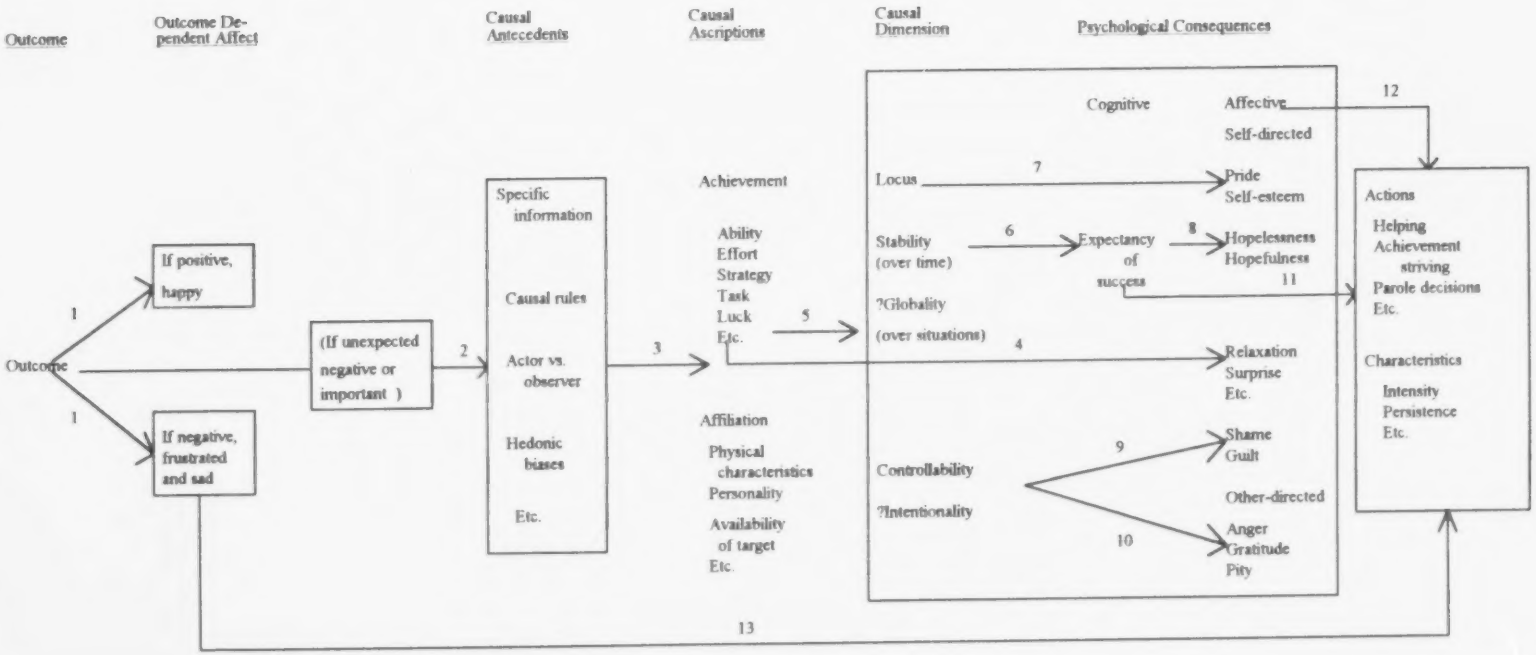

Figure 1. An attributional theory of motivation and emotion.

Note. From "An Attributional Theory of Achievement Motivation and Emotion" by B. Weiner, 1985, Psychological Review, 92, p. 565. Copyright 1985 by the American Psychological Association. Adapted with permission.

seen as unstable this may encourage a sense of hopefulness which in turn may promote attempts to pursue help.

Also of interest are the implications of differential cause or cure attributions on the locus and controllability dimensions. It is reasonable to assume, using Weiner's framework, that if psychological or behavioural problems are attributed to internal causes (link 7) then the individual suffering from such difficulties may experience diminished self-esteem. Concomitantly, attribution of cause for psychological or behavioural problems to external sources may mitigate loss of self-esteem. As well, depending on the individual's causal attribution regarding controllability (link 9) of psychological or behavioural problems, shame (uncontrollable) or guilt (controllable) may result. Following the same reasoning, attributions by others, as to the individual's degree of control over the psychological or behavioural problem (link 10), may produce either pity (uncontrollable) or anger (controllable) toward him or her.

In sum, Weiner provided a framework in which to evaluate the types of information that people use to assign causality to various factors perceived as relevant to events that occur in their lives. He also provided a scheme that linked these attributions to emotional responses and expectancy of future outcomes. Finally, he created a conceptual link between the affective responses and expectancy, and the behavioural consequences that follow the attributional search. It remained for other investigators to apply this framework to the area of beliefs about the causes and cures of psychological and behavioural problems.

Beliefs about the causes and cures of psychological problems

In the same way as other attributional research is conducted, there are two approaches that dominate the area of research into peoples beliefs about causality. The first is a free-response procedure, in which subjects are presented with a scenario or description of a phenomenon, and asked to list all of the causes (or other features) they feel are relevant to the phenomenon under study. These responses are then categorised (or factor analysed) to determine underlying constructs that characterise various groups of responses. In the second approach, subjects are provided with a list of responses (often derived from pilot studies involving free-response paradigms) which they are asked to rate with respect to the phenomenon under study (Weiner, 1983). The following review includes studies that have employed either, and in some cases both methodologies.

The studies reviewed were divided into three categories. The first four studies are based on Nunnally's (1961) methodology. Following these are six studies associated with Weiner's attributional framework. The review concludes with three studies that assess the association between aetiological conceptualisations and help-seeking behaviour.

The Nunnally studies

Nunnally's studies represent the conceptual foundation for the study of beliefs about psychological problems. He was one of the first researchers to systematically examine lay people's beliefs in this context. Nunnally employed a wide variety of methodologies in his research from free response techniques to content analysis of newspapers and magazines. The work conducted by Nunnally that is reviewed here is taken from a group of studies

that were conducted over a five year period and were chosen since they are the methodological forerunners to both the remaining studies in this category and many of those in the following category addressing Weiner's attributional framework. The other three studies in this category were included for their relevence to the current research.

Nunnally (1961)

In a seminal group of studies, Nunnally (1961) examined the extent of the public's knowledge about the causes and cures of mental disorders, and about people suffering from such problems. In the first three studies Nunnally used questionnaires, constructed using a free-response method, to compare the beliefs of 600 lay people with those of 300 psychologists and psychiatrists. Nunnally's questionnaires required subjects to rate their degree of agreement or disagreement to items such as: "X-rays of the head will not tell whether a person is likely to develop insanity" and "People who become mentally ill have little will power" (1961, p. 261).

Using factor analysis Nunnally (1961) extracted 10 "informational factors" which were endorsed to varying degrees by subjects. Items that constituted the factors carried the following implications (the relative level of endorsement by the lay sample follows each factor in brackets). The mentally ill are distinguishable from normals by external characteristics (low). Lack of willpower causes mental disorders and increased willpower ameliorates them (low). Women are more prone to mental disorder than men (high). Mental health is maintained by focusing on pleasant thoughts (high). Mental illness can be ameliorated by the positive influence of well adjusted people in the environment (high).

Overall, the long-term prognosis for people with mental disorders is poor (low). Pressures in the immediate environment, rather than internal personality dynamics, cause mental illnesses, and improvements in the environment can alleviate them (high). Most mental illnesses are not seriously debilitating (high). Susceptibility to mental disorder increases with age (low). Dietary factors, physical damage and diseases of the nervous system cause mental disorders, biological interventions can ameliorate them (low) (Nunnally, 1961, p.23).

Of interest in the context of the current study was the degree of endorsement by Nunnally's subjects, who represented 'average' American lay people, on a number of the causal and curative factors. Nunnally's (1961) subjects assigned relatively low importance to the role of factors such as willpower and organic causes. At the same time, factors such as the causal influence of environmental pressures (and the curative efficacy of improving the environment) and the prophylactic or curative efficacy of positive thinking (pleasant thoughts) were accorded relatively higher importance.

Arkoff, Thaver and Elkind (1966)

In the first cross-cultural study of its kind Arkoff, Thaver and Elkind (1966) used Nunnally's (1961) 60 item questionnaire to compare the beliefs of psychologists and American students with those of Asian (Chinese, Filipino, Japanese and Thai) students about mental disorder. The results of the study revealed that, relative to the former two groups, Asian students believed that willpower and the avoidance of unpleasant thoughts played a much greater role in enhancing mental health. Further, Asian students assigned

more significance to the efficacy of guidance and support as a curative factor than did either of the American comparison groups. Asian students, more than American students or psychologists believed that counselling was a "directive, paternalistic and authoritarian process" (Arkoff et al., 1966, p. 219).

Sue et al. (1976)

Sue, Wagner, Ja, Margullis and Lew (1976) also used Nunnally's (1961) questionnaire to compare the beliefs of Caucasian and Asian-American students about mental disorder. Their findings partially supported those of Arkoff et al. (1966). Asian students were found to believe, more strongly than American students, that "the mentally ill look and act different, that will-power is the basis of personal adjustment, that women are more prone to mental disorder than men, that the avoidance of morbid thoughts enhances mental health and that mental illness is brought on by organic factors" (Sue, et al., 1976, p. 705). After controlling for demographic and educational variables, however, only two significant differences remained. Asian students, more than their Caucasian counterparts, believed that avoidance of morbid thoughts militated against mental illness and that mental illnesses were the result of organic factors.

Sue et al. (1976) asserted that the belief that mental health is enhanced by avoiding morbid thoughts is consistent with the notion that Asian cultures generally emphasise self control. Further, they indicate that the attribution of organic causes for mental illness is consistent with the, often cited, tendency for Asians to somatise psychological distress. Kleinman (1986) and Sue and Sue (1974) maintain that it is more acceptable in Asian

cultures to express physical symptoms than emotional difficulties. These authors indicate that the tendency to somatise may provide a more socially acceptable mantle for the expression of psychological distress.

Furnham and Rees (1988)

Influenced by the work of Nunnally (1961), Furnham and Rees (1988) studied lay theories of schizophrenia in a British sample. In a two stage research project they examined subjects' beliefs about the characteristics of schizophrenics and the perceived causes of the disorder. The results of the first stage indicated that, to varying degrees, subjects perceived people suffering from schizophrenia as dangerous (unpredictable), amoral (untrustworthy), egocentric (oblivious) and vagrant. Results of the second stage indicated that perceived causes coalesced into five factors: stress and pressure, biological, genetic, backwardness (cognitive deficit), and brain damage. From these results Furnham and Rees (1988) concluded that lay causal explanations strongly resembled formal theories of causality for schizophrenia. They stated that "subjects seemed to prefer environmental explanations referring to social stresses and family conflicts. This would indicate that in Britain, a psychosocial model of mental illness is adhered to, rather than a medical model" (Furnham & Rees, 1988, p. 218).

In sum, British and white American subjects seem to hold a psychosocial model of psychological problems, whereas the Asian subjects tended to favour organic explanations about causality. Further, Asian subjects seemed to assign greater importance to the role of

will power and the avoidance of morbid thoughts in the cause and cure of these problems than their American counterparts.

Research Associated with Weiner's Framework

These studies extended Nunnally's (1961) work and, except for the first, represent the innitial attempts to incorporate Weiner's framework into the examination of beliefs about the causes and cures of psychological problems. The studies in this series are also related in that each study directly builds on its predecessor.

Knapp and Delprato (1980)

Knapp and Delprato (1980) took a somewhat different approach to the study of beliefs about psychological problems. While their study did not address Weiner's attributional framework, it was the forerunner of many of those that did. Focusing on the role of willpower, Knapp and Delprato asked their subjects to rate the degree to which it was important in overcoming 24 behavioural problems. Their analysis revealed that willpower was perceived to be differentially important to overcoming four classes of problems. "Willpower was rated as more necessary for overcoming 'Self-indulgence' problems (e.g., alcoholism, smoking) and certain 'non-self-indulgence' problems (e.g., shyness, fear of flying) than for overcoming 'psychopathological problems' (e.g., nervous breakdown, hallucinations) and 'ability deficits' (e.g., inability to swim, poor mathematical ability)" (Knapp & Delprato, 1980, p. 477). The authors discuss the findings in relation to the efficacy of behaviour modification techniques. They speculate that the efficacy of this

therapeutic approach may be attenuated for those problems in which willpower is perceived a necessary curative factor.

Knapp and Karabenick (1980)

In an extension of Knapp and Delprato's (1980) study, Knapp and Karabenick (1985) examined the importance of 20 contributors (attributions) to overcoming six psychological problems. For this study the authors selected problems from two categories studied by Knapp and Delprato (1980): smoking, overeating (self indulgence problems), nightmares, hearing voices, stuttering and fear of dogs (psychopathological problems). Citing the importance of client attributions to the therapeutic process, Knapp and Delprato indicate that they used Weiner's (1980) attributional framework as a guide when selecting the contributors (attributions) used to construct their questionnaire.

Knapp and Karabenick (1985) extracted four factors from the data: "Social Consequences, Inner Control, Understanding and Positive Outlook-Instrumental Approach" (p. 349). In terms of willpower (inner control), the study supported the findings of Knapp and Delprato (1980). Subjects rated this factor as most important for overcoming self indulgence problems such as smoking and overeating. The contributors that made up the Understanding and Positive Outlook (Instrumental Approach) factors were rated as more important than Inner Control for overcoming problems that imply some underlying psychopathological or medical condition (nightmares, hearing voices, stuttering and fear of dogs). The Social Consequences factor was perceived to be the least important in overcoming the problems studied (Knapp & Karabenick, 1985).

Two aspects of this study are of particular interest in the context of the current research. Knapp & Karabenick (1985) speculated that the importance assigned to the Understanding and Positive Outlook (Instrumental Approach) factors may indicate that subjects believe that "these problems are symptomatic of something else that needs to, and can be, addressed, but not through personal effort alone" (p. 351). Concomitantly, they hypothesise that the greater importance ascribed to Inner Control for ameliorating the self indulgent problems may diminish people's tendency to seek professional help for these problems, in that they may believe that they should be able to overcome such difficulties on their own. If true, these types of attributions have important implications for both help-seeking and the efficacy of interventions.

Henley and Furnham (1988)

Henley and Furnham (1988) extended the Knapp and Karabenick (1985) study and examined four different problems: alcoholism, depression, sexual problems and shyness. Their analysis revealed seven factors: Inner control, Receiving help, Understanding, Social consequences, Avoidance, Physical basis and Fate. The first four factors were perceived as relatively important to overcoming the problems included in the study, while the latter three were considered relatively unimportant. Henley and Furnham found that the rated importance of the factors differed significantly across problems. Inner control was rated as the most important factor in overcoming alcoholism and shyness. In relation to depression, the receiving help factor was rated highest. Understanding the problem was seen as the most important factor in overcoming sex problems.

Henley and Furnham (1988) note that the generally high importance placed on Inner control, Receiving help and Understanding for overcoming all four problems has implications for the nature and efficacy of various intervention strategies. They reason that Inner control (implying self-help) and Receiving help are not antithetical. They argue that "family, friends and professional helpers may be invaluable, even necessary, sources of support and advice concerning appropriate curative strategies, but the successful implementation of these strategies may depend to a large extent on the will-power and personal effort of the individual concerned" (Henley & Furnham, 1988, p. 386). In terms of the Understanding factor, they assert that if this proves to be an integral aspect of lay beliefs about overcoming problems, then providing clients with explanations of their problems may facilitate successful therapeutic outcomes.

Furnham and Henley (1988)

The same researchers undertook a second study of lay beliefs regarding overcoming psychological problems. Furnham and Henley (1988) used the same set of contributors to examine subjects beliefs regarding four less common problems: agoraphobia, anorexia nervosa, compulsive gambling and schizophrenia. Their analysis revealed five clearly interpretable factors: inner control, understanding/help, avoidance, physical basis and fate. The authors indicated that this factor structure was very similar to those found by Knapp and Karabenick (1985) and Henley and Furnham (1988). They note that these similarities are all the more remarkable in that subjects in the three studies were rating very different target problems.

Furnham and Henley (1988) found that the 'inner control' factor was perceived to be differentially important for overcoming all four problems. It was rated as the most important factor for overcoming both agoraphobia and anorexia nervosa, less for compulsive gambling and least so for schizophrenia. 'Understanding and receiving help' were seen as highly important in overcoming both agoraphobia and anorexia nervosa, and least important in overcoming schizophrenia. 'Avoidance' and 'fate' were rated significantly more important in overcoming compulsive gambling than for the other three problems. Schizophrenia was perceived most strongly as having a 'physical basis' (Furnham & Henley, 1988). The authors speculate that the nearly identical ratings of cure attributions for agoraphobia and anorexia nervosa indicates that these disorders, despite their very different symptomatology, might be perceived by lay people as having very similar causes and cures. Furnham and Henley (1988) also comment that the attributions of cure factors for both compulsive gambling and schizophrenia are quite realistic and, by implication, congruent with current clinical thought about these two disorders.

Furnham (1989)

Furnham (1989) replicated the Henley and Furnham (1988) and Furnham and Henley (1988) studies, examining lay beliefs about the cures for 'psychosomatic' illnesses (hypertension, peptic ulcer, asthma, dermatitis and migraine). Results from this study supported the factor structure found in the previous two studies (Henley & Furnham, 1988; Furnham & Henley, 1988). However, unlike the previous studies Furnham's (1989) subjects rated the Understanding and Receiving help factors as more important in overcoming these disorders than the Inner control factor. A second finding was that the

various factors did not distinguish significantly between problems. Furnham (1989) concluded that this may indicate that "subjects may have been less clear about the aetiology and hence cure of 'psychosomatic' problems and hence tended to see less difference between them" (p. 66).

Luk and Bond (1992)

The current research is a replication and extension of this particular study. Because of its relevance to the current research it is covered it in somewhat greater detail than the other studies reviewed. Luk and Bond (1992) replicated and extended the study by Furnham and Henley (1988). In this study the authors examined beliefs of Hong Kong Chinese lay people about both the causes and cures of ten psychological and behavioural problems. In addition to examining beliefs of a different cultural group, Luk and Bond extended the list of cure attributions, then adapted and expanded the list to elicit attributions of cause. Analysis resulted in two factors among the causes (environmental-hereditary and social-personal) and three factors among the cures (commitment, clinical methods and protection).

The environmental-hereditary cause factor subsumed both internal and external attributions such as the individual's genetic complement, resistance to germs and his or her workload and interpersonal environment. The social-personal cause factor again included internal and external attributions that related to the ability, and education of the individual, and the person's interaction with others having the same problem. The commitment cure factor included primarily internal attributions relating to the individual's degree self control

and his or her attempts to obtain help from friends or family. The clinical methods cure factor was considered interactional, in that it included internal and external attributions relating to the individual's resistance to disorder and whether the person got professional help. The protection cure factor was also interactional, and included attributions that related to the "prophylactic effect of moral and educational training and the interaction with others for protection against these problems" (Luk & Bond, 1992, p. 149).

Luk and Bond's (1992) cluster analyses grouped the ten problems into three clusters according to the ratings of the causes, and four clusters according to the ratings of the cures. In terms of the causes, compulsive gambling, using the back door, lack of civic responsibility, social apathy and child abuse formed the first cluster, labelled "antisocial behaviours"(this categorisation was also adopted for the current research). Shen-kuei constituted a lone category according to its causal ratings. The third cluster, labelled "psychological-behavioral disturbances" subsumed schizophrenia, agoraphobia, anorexia nervosa and neurasthenia (the later two clusters constitute the adult pathological category in the current research).

The same procedure, analysing cure ratings this time, clustered compulsive gambling, using the back door, lack of civic responsibility and social apathy into a group labelled "greediness problems". Again, Shen-kuei was perceived as distinct from all other problems according to its cure ratings. The third cluster, labelled "psychiatric problems" included schizophrenia and neurasthenia. The fourth cluster, derived from the cure ratings,

included anorexia nervosa, agoraphobia and child abuse, and was labelled "emotional problems" (Luk & Bond, 1992, pp. 152-154).

Luk and Bond (1992) used ANOVA to examine the importance of the cause and cure factors in relation to the problem clusters. The environmental-hereditary factor was rated as the most important cause of psychological-behavioural problems, and less important in causing Shen-kuei and compulsive gambling. The social-personal factor was perceived as the most important cause of antisocial behaviours, less so for psychological-behavioural problems and almost irrelevant to Shen-kuei.

In terms of cures, the commitment factor was rated highly for all types of problems, but highest for overcoming psychiatric and greediness problems, and lowest for Shen-kuei. Clinical methods were regarded as most important for overcoming psychiatric problems and least important for greediness with the other two clusters falling between these two. Protection was seen as the most important factor in overcoming greediness problems, moderately so for both psychiatric and emotional problems, and virtually unimportant in overcoming Shen-kuei (Luk & Bond, 1992).

Finally, Luk and Bond (1992) also examined the correlations between cause and cure factors. They found that "the more a problem was perceived to be caused by the environmental-hereditary factor, the more it was perceived to be curable by clinical methods. The more a problem was perceived to be caused by the social-personal factor, the more it was perceived to be curable by the protection factor" (Luk & Bond, 1992, p.

154). The commitment cure factor was perceived to be generally important in ameliorating all types of problems. One of the authors' principal conclusions was the idea that Hong Kong Chinese perceive causes and cures of psychological and behavioural problems to be interactional. That is, Hong Kong Chinese perceived internal and external causes and cures to be important to the same problem. This contrasts with the results found among British and American subjects. The internal and external attributions of the latter two groups tended to be more discrete, and dependent on the particular problem being examined.

The above studies reveal a number of interesting findings about the beliefs of lay people regarding the causes and cures of psychological problems. Both American and British subjects perceived the role of will power as important, but chiefly in terms of self-indulgence types of problems. Asian subjects assigned relatively greater importance to the causal and curative efficacy of will power across the full range of psychological problems. Also, Asian subjects perceived a greater causal role for organic factors (internal) than either their British or American counterparts, and tended to ascribe a similar causal role to external attributions with respect to the same problems. The exception to this was seen in the final study (Luk & Bond, 1992) where the Chinese subjects discounted the role of organic causes with respect to the antisocial behavioural problems.

As noted by Luk and Bond, the Chinese subjects tended to hold a more interactional view of the causes and cures of psychological problems than did the subjects of Western origins. Evidence for this contention is also found in the number and content of the factors derived from these studies. The American and British studies found five and seven factor

solutions in their analyses. This would seem to indicate that subjects in these studies differentiated between attributions in terms of locus, stability and controllability. Using an identical analytical approach, Luk and Bond found only two factors among the causal attributions studied (and three among the cures). This would seem to indicate that the Chinese subjects made fewer distinctions between cause (and cure) attributions, associating different attributions from all three causal dimensions.

Problem Conceptualisation and Help-seeking

The studies in this last category represent attempts to examine beliefs or attributions about the causes of psychological problems in relation to the help seeking behaviour of Asian populations. This research directly addresses the application of the analysis of belief structures surrounding psychological problems to subsequent attempts to overcome such problems.

Cheung (1987)

In her study of psychiatric patients in two clinics in Hong Kong, Cheung (1987) found that the initial aetiological conceptualisation of disorder held by patients (psychological, somatic or mixed), influenced the nature of their initial coping attempts, the length of time they took to seek consultation and the type of help they sought. Those who initially believed that their problem was purely psychological, focused on self-directed psychological coping methods and delayed seeking professional help. When they did seek outside help, these patients were more likely than the other two groups to approach mental health professionals. Those with purely somatic initial conceptualisations of their

problems tended to seek help sooner but approached medical (Traditional Chinese and Western) practitioners, and were the last of the three groups to acquire psychiatric or psychological consultation.

The group of patients who held a mixed aetiologic conceptualisation of their problems sought help earliest in both the medical and psychological/psychiatric modalities. Cheung (1987) speculates that the somatic component of their beliefs may have caused these patients to approach medical professionals first, and that disclosure of the psychological component of their distress subsequently brought them to the attention of mental health professionals. Cheung cautions that the retrospective nature of the study makes it impossible to determine whether the patients' conceptualisations of disorder motivated their choice of intervention strategies or whether the strategy informed the conceptualisation.

Ying (1990)

Ying Yu-Wen (1990) presented 40 Chinese-American immigrant women with a vignette, depicting a fictitious Chinese woman, 'Mrs. Wong', suffering from major depression, to assess their explanatory models and help-seeking preferences in relation to this disorder. Among the results of the study, was the finding that 23 of the subjects conceptualised 'Mrs. Wong's' problem as primarily psychological. These women cited external pressures, including stress and interpersonal conflicts as the primary causal agents. The majority (16) of these subjects did not recommend that Mrs. Wong seek

professional help. Rather, they felt that she should rely on herself, family and friends to alleviate the problem.

Twelve of the remaining seventeen subjects indicated that Mrs. Wong's problem was primarily a physical (somatic) disorder (the remaining five indicated that they were uncertain about the nature of the problem). These women also cited external causes for the problem, but recommended professional (medical) help to overcome it. Ying (1990) notes that those who thought the problem was "primarily psychological, [mentioned] physical consequences of [the] illness; and those who hold a physical conceptualization also cite psychological impacts" (p. 403).

Narikio and Kameoka (1992)

In a study of attributions of mental illness and judgements about help seeking among Japanese-American and white American students, Narikiyo and Kameoka (1992) found that Japanese-American students were more likely than their white counterparts to "attribute mental illness to social causes, to resolve problems on their own, and to seek help from family members or friends or both." (p. 363). The authors hypothesise that the Japanese emphasis on harmony in social relationships may lead to the inclination to attribute social causation to mental disorder. They assert that the greater tendency to stigmatise mental disorder, and the burden of responsibility for maintaining face (the honour of the individual and family) lead to the propensity toward resolving problems on their own and seeking help from family and/or friends before pursuing professional assistance.

These factors were all thought to influence the significant underutilisation (also examined in the study) of mental health services by the Japanese-American students. The main effect of ethnicity on help-seeking attitudes and behaviour was found to be very robust in spite of the fact that a large proportion of their Japanese-American subjects were third and fourth generation Americans (Narikio and Kameoka, 1992). This argues against the modulating effects of acculturation on culturally shaped behaviours. While this study examined the effect of beliefs on help-seeking behaviour of Japanese as opposed to Chinese subjects, Sue and Sue (1974) argue that the two cultures share sufficient features, with respect to problem formulations and social conventions, to make them comparable.

In sum, these studies provide evidence of two important characteristics of attributions about psychological problems. First, these studies support the notion that Chinese lay people tend to hold an interactional view of psychological problems. Second, and perhaps more important, is the way that disparate aetiological attributions influence the types of help that people with these problems will access. Purely psychological views of disorder led to initial attempts to solve the problem without professional intervention. Somatic conceptualisations led initially to seeking help from medical practitioners. The interactional view brought the individual most quickly to the attention of mental health professionals. Finally, the Narikio and Kameoka (1992) study implies that the influence of attributions on subsequent behaviour is not limited to first generation immigrants. Instead, culturally inculcated beliefs exerted a significant influence on the perceptions of even members of the third and fourth generations of immigrant families.

Chapter summary: Bernard Weiner developed a framework that could be used to categorise the various types of information people use to ascribe causes to the different phenomena they encounter in everyday experience. Further, he linked these causal attributions to affective and behavioural consequences of the attributional search. The research on attributions indicated that the beliefs about the causes and cures of psychological problems held by Chinese lay people differ from those of non-Chinese lay people in Britain and the United States. Specifically, the Chinese ascribed greater role to will power in causing and curing a wider range of problems than did their Western counterparts. They also seemed to hold a more interactional view of psychological problems than those of lay people in the West, ascribing causality and cure to a mixture of factors from all three attributional dimensions. Finally, as a result of their belief structures, Chinese individuals tended to respond differently than those in the West in the ways in which they attempt to overcome psychological problems.

Chapter III

Research Design

Sample:

Selection procedure:

The limited availability of subjects from the People's Republic of China (PRC) in Edmonton necessitated selection on the basis of convenience. The aim of the selection procedure was to gather as heterogeneous a group of subjects as possible, while limiting the sample to individuals who's cultural background derives from the milieu of the PRC. Many of the people currently residing in Edmonton who have come from the PRC are graduate students. During the 1993/94 academic year the total number of students from the PRC, both full- and part-time, was 415 (Office of the Registrar, 1994). In an attempt to distribute the questionnaire to a more representative group of mainland Chinese, efforts were made to include adult members of the students' families (i.e., to spouses, parents etc.) and non-students in the sample.

There were two distributions of the questionnaire. In the first distribution of the questionnaire, 120 individuals attending a Chinese New Year celebration hosted by the Chinese Students and Scholar's Association (CSSA) were approached at random and asked to participate in the study. Since this is a family oriented gathering which normally elicits wide participation within the mainland Chinese community, it was felt that the nature of this gathering would facilitate distribution of the questionnaire to the largest and

most heterogeneous sample. For the second dispersal, Chinese friends and associates of the researcher circulated the questionnaire to other members of the mainland Chinese community.

Description:

The sample consisted of 112 individuals from various parts of mainland China who resided in Edmonton at the time of the study. The primary criteria for inclusion was that potential subjects be born and raised in mainland China, and that they had not taken courses in psychology or psychiatry. The sample was made up of 57% males and 43% females. Excluding the 3.6% of the sample who failed to report marital status, the majority of respondents, 93.5%, were married. Single respondents constituted 4.6% of the sample, while the divorced and widowed each accounted for 0.9%. None of the people in the sample were 20 years of age or less. The two largest groups of subjects were in the age ranges 21 to 30 years (32%), and 31 to 40 years of age (56%). The balance of the sample consisted of individuals in the age ranges 41 to 50 years (8.9%), 51 to 60 years (1.8%) and over 70 years (0.9%).

Subjects were also asked general questions regarding their origins and residency within China. Excluding the 2.7% of the sample who did not respond to this question, 63.3% reported being from the south of China and the remaining 36.7% came from the north. Again, excluding the portion of the sample that failed to respond to this question (1.8%), 84.5% reported urban origins and 15.5.% came from rural backgrounds. It is interesting to note that the frequencies reported in this category (urban vs. rural),

represent almost a perfect reversal of the proportions as they exist in China; approximately 80% of Chinese reside in the country while the remaining 20% are city dwellers.

Subjects were asked how long they had been outside China. Those who reported spending less than one year away from their homeland constituted 10.7% of the sample, while 14.3% had been away for one to two years. The largest proportion, 54.5%, indicated that they had been away from China for a period of three to five years. The latter three groups, constituting 17.9%, 1.8% and 0.9% of the sample, report spending 6 to 10 years, 11 to 20 years and more than 20 years, respectively, outside China.

Finally, subjects answered questions regarding their employment and educational status. Excluding the 3.6% of the sample who left this question blank, 48.1% reported being employed full time, 3.7% worked part-time and 2.8% held more than two jobs. Twelve percent reported being unemployed, 1.9% were retired and 31.5% reported being full-time students. In terms of education, 35.1% report holding a doctorate, while those with master's and undergraduate university degrees made up 24.3% and 27%, respectively, of the sample. College graduates were the next largest group at 8.1%, and individuals with high school and jr. high school education constituted 4.5% and 0.9%, respectively, of the sample.

Instruments

The primary questionnaire used in the study was a version of that used by Luk and Bond (1992) with only slight modifications. The original questionnaire was first translated into English and than back translated into Chinese to ensure consistency of meaning with

the British forms (Henley & Furnham, 1988; Furnham & Henley, 1988). Only slight modifications were made to alter the content of the questionnaire to make it more relevant to a mainland Chinese sample (e.g., a reference to a specific temple in Hong Kong was replaced with a generic reference to temples in China). The text of the questionnaire was converted from traditional Chinese characters to their simplified form. The simplified form is currently used in mainland China (i.e., Modern Standard Chinese), as a result, many Chinese from the mainland are unable to read traditional characters.

Description

A complete questionnaire consisted of 14 pages (see appendices A, p. 109 and B, p. 118). The first page consisted of a brief description of the study and its purpose. The second page included instructions for filling out the questionnaire, an assurance of confidentiality, a section addressing ethical issues and a brief questionnaire to gather personal information. The rest of the questionnaire constituted the main body and consisted of three sections of four pages each. Each of the three sections differed only with respect to the particular disorder for which the cause and cure attributions were rated.

The first page of each section began with a brief description of the disorder to be rated. This description was followed by 26 cause attributions, which were headed with the statement: "Following are some possible factors that might cause a person to have this disorder". This list extended onto the second page of the section.

The third page of each section was headed by the statement: "Following are some possible important factors that might influence a person in getting over this disorder". This was followed by the 36 cure attributions which extended to the fourth page of the section. To the right of each of the cause and cure attributions was a 10 point (zero to nine) Likert scale. The scale was headed on the top-left (zero) by the word 'Unimportant' and on the top-right (nine) by the word 'Important'. Finally, at the end of each list of cause and cure attributions was a three (blank) line section meant to elicit further comments. This was headed by the sentence: 'Please list here any additional causal/curative factors you feel are important to our understanding of this problem'. In order to control for the possibility of response sets resulting from the order of presentation of the problems, two variations of each questionnaire were administered. In the first version the antisocial behavioural problem was presented first, followed by the adult pathological problem and the child pathological problem was presented last. In the second version, the order was reversed such that the child pathological problem was presented first, followed by the adult pathological problem and the antisocial behavioural problem was presented last.

The Problems

The problems examined in the study (see appendices A, p. 109 and B, p. 118) were the ten used by Luk and Bond (1992) plus five additional problems generally judged have childhood onset in the DSM-III-R (1987). Four of the ten problems used by Luk and Bond (1992) were first studied by Furnham and Henley (1988). In this latter study, Furnham and Henley included Agoraphobia, Anorexia Nervosa, Compulsive Gambling and Schizophrenia on the basis of their salience in the public realm. Luk and Bond (1992)

selected the additional problems (child abuse, social apathy, using the back door/corruption, lack of civic responsibility, shen-kuei and neurasthenia) on the basis of interviews with Chinese lay subjects and the salience of the (latter two) disorders as popular Chinese diagnostic categories in both the lay and professional communities.

Each form of the questionnaire presented three problems to be rated. One from each category of antisocial behaviours, adult pathological, child pathological. These categories were based on the cluster analysis of the causal attributions conducted by Luk and Bond (1992) and the DSM-III-R classification of childhood disorders (American Psychiatric Association, 1987). The distribution of disorders within categories was as follows: 1) Antisocial behaviours: Compulsive Gambling; Child Abuse; Social Apathy; Using the Back Door (Corruption); Lack of Civic Responsibility. 2) Adult pathological: Shen-Kuei Syndrome; Neurasthenia; Agoraphobia; Anorexia Nervosa; Schizophrenia. 3) Child pathological: Mental Retardation; Autistic Disorder; Attention-Deficit Hyperactivity Disorder; Conduct Disorder; Learning Disability (Academic skills disorders).

Validity Considerations

A panel of five expert judges evaluated each of the cause and cure attributions with respect to the three dimensions of Weiner's attributional framework. The raters all held doctoral level degrees in psychology. Three of the judges were professors of psychology (one from each of the following areas: counselling, social-cognition and cross-cultural). The remaining two judges were recent PhD graduates in counselling psychology (one with an emphasis on counselling and the other on neuropsychology). Each judge was provided

with a list of the attributions (see Appendix C, p. 125), each of which was rated on the three dimensions of Weiner's attributional framework using a five point Likert scale. The first scale addressed locus of the attribution, and was labelled as follows: 1 = Definitely Internal; 2 = More Internal than External; 3 = Cannot Define; 4 = More External than Internal; 5 = Definitely External. This scale was followed by two more scales, assessing, in the same way, the degree to which the attribution was controllable and stable.

Reliability Estimates

Given the nature of participation in the study (i.e., anonymous responses) it was not possible to retest subjects in order to establish the stability of the ratings over time. Since previous studies were conducted using samples from different populations, comparison for the sake of reliability purposes were not possible. There were no reliability estimates reported in any of the previous studies in which the various forms of this questionnaire were used. Therefore, it is assumed that reliability tests were not conducted in those instances. While it was not reported in this context in the previous literature, the high consistencey between the factor structures found by the various researchers (excluding Luk & Bond, 1992) would seem to provide a degree of support for the reliability of the basic structure of the questionnaire.

Scoring procedure

As mentioned above, each of the attributions was rated on a ten point Likert-type scale. A rating of zero constituted an endorsement "Unimportant" and a rating of nine constituted an endorsement of "Important".

Administration times and conditions

Subjects were each given the questionnaires to complete independently. It was felt that due to the length and nature of the questionnaire, this approach would promote the highest participation and return rate possible. Completed questionnaires were either returned to the researcher by mail, or in person to either the researcher or others that helped in the second distribution. Feedback obtained from six respondents, known to the researcher, indicated that the questionnaire required approximately 40 min. to complete.

Data Analysis

Questions Examined

1. What cause and cure attributions do the subjects rate as important and which were perceived as unimportant overall.
2. Which cause and cure attributions were rated as important and which were rated as unimportant for each of the psychological or behavioural problems presented.
3. How do these ratings compare with those found in studies in British and Hong Kong populations.
4. How were subjects' ratings of cause and cure attributions arrayed in relation to Weiner's attributional framework

Statistical procedures

The SPSS version 6.0 (Windows version) was used to conduct the statistical analysis. Descriptive statistics were used for the analysis. It was felt that this approach

offered the greatest degree of simplicity while ensuring minimal loss of detail within a large data set.

For the first analysis, ratings were collapsed across problems. Means, standard deviations and medians were calculated for each of the cause and cure attributions (see Tables 4, p. 145 and 8, p. 150). Next, grand means and standard deviations for all causal attributions and then for all curative attributions were calculated. Means for each attribution across all problems were compared with the grand mean for either cause attributions or cure attributions (see appendices E, p. 144 and F, p. 148). The second analysis, and means for each attribution by problem were examined in relation to the grand mean of either the cause attributions or the cure attributions.

For the analysis of the expert ratings, means were calculated separately for each attribution within each dimension (locus, controllability and stability). The literal ratings for each of the dimensions were applied by virtue of the significance criteria outlined below.

Criterion for judging significance

In order to facilitate the analysis it was decided to divide the distribution of scores into three parts. Mean ratings that were one standard deviation below their respective grand mean were considered as constituting an endorsement of "Unimportant" for a given attribution. Ratings one standard deviation above their respective grand mean for each type of attribution were taken as signifying an endorsement of "Important". This eliminated mean ratings that occupied the 68% of the distribution around the grand mean.

Given the range of possible responses on a ten point (zero to nine) scale it was thought that fine discriminations of one or two points would be essentially meaningless. On the basis of discussions with other researchers and statistical consultants, it was reasoned that this middle 'two thirds' of the distribution straddling the mean could reasonably be taken to denote an endorsement of 'Moderately Important/Unimportant' for the attribution being considered.

In terms of the expert ratings it was decided that mean ratings above 4 would represent agreement as to a rating of either Internal, Controllable or Stable. Mean ratings equal to or below 2 represent agreement as to a rating of External, Uncontrollable or Unstable. Mean ratings above 2 and below 4 correspond to a rating of undefined.

Limitations

1. Since this was essentially a replication of Luk & Bond (1990), there was little deviation from the original questionnaire used in that study. A conscious effort was exerted to maintain, as much as possible, the original form of the instrument to ensure the highest level of comparability between the two studies. The validity of the various attributions employed in the questionnaire was tested post-hoc for the purposes of evaluation in terms of Weiner's attributional framework.

2. Compared to the general population of mainland China, this was a highly selected and well educated sample. The population sampled in the study cannot be assumed to be representative of the mainland Chinese population as a whole. The sample does seem, however, to be reasonably representative of the immigrant population of mainland Chinese

that has arrived in Canada within the last decade. Therefore, the results of this study cannot be generalised beyond this population.

3. It could be argued that since this was not a clinical sample the findings are limited in terms of generalisability to populations actually suffering from the problems under study. The questionnaire did not include any questions relating to the personal experience of respondents with any of these problems. However, seems likely that the participants in this study are subject to the same risk of succumbing to any of the problems as any member of the general population. Their insights are taken to be valid in this context (i.e., that the study was meant to measure lay beliefs).

4. As with other research employing a survey questionnaire methodology, there is the danger of introducing bias in the results due to the voluntary nature of participation (self-selection by the subjects), considerations of social desirability in responding and the influence of general response sets.

5. The fact that the items included for rating were developed a-priori limits the validity of the study. A more valid approach would have been to conduct an ethnographic inquiry to determine the nature of popular beliefs among mainland Chinese about cause and cure of psychological problems, develop a questionnaire from the results of this survey and then administer the new instrument to a large sample of mainland Chinese. The nature of the study (replicative) precluded this approach. However, while provision of the open-ended response section at the end of each subsection was intended to allow for idiomatic input, very few subjects added additional comments. This may have been due to the extensive length of the questionnaire, or the already exhaustive list of attributions.

Chapter IV

Results

Results of Expert Ratings

There was a significant number of attributions that judges rated as undefinable in terms of one or more the dimensions of Weiner's (1980) attributional framework (see Appendix D, p.140). The section that follows indicates the attribution by its ordinal number in its respective list, the English translation of the attribution and the literal rating assigned by the panel of expert judges. Those attributions for which the mean score did not meet the criteria for assignment to one end or the other of a particular dimension are listed as 'Undefined'.

Attributions of Cause

1. The problem is caused by the person's genetic disposition.
- Internal
- Uncontrollable
- Stable

2. The law does not proscribe the problem.
- External
- Uncontrollable
- Stable

3. The person lacks social prestige and high status.
- External
- Undefined
- Undefined

4. The person lacks correct information about the problem.

- Undefined
- Controllable
- Undefined

5. The problem is caused by some other deep-rooted problem.

- Undefined
- Undefined
- Undefined

6. The person is unlucky or predestined to have the problem.

- Undefined
- Uncontrollable
- Undefined

7. Traditional background approves the existence of the problem.

- External
- Uncontrollable
- Stable

8. There is something wrong with the person's brain or nervous system.

- Internal
- Uncontrollable
- Stable

9. His/her quality of life is low (e.g. material life).

- External
- Undefined
- Undefined

10. S/he lacks the intelligence or ability to manage things.

- Internal
- Uncontrollable
- Unstable

11. His/her past experience (e.g. upbringing) is different from that of normal people.

- External
- Undefined
- Undefined

12. S/he has very frequent contact with the mass media (e.g. watching TV or reading periodicals).

- External
- Controllable
- Undefined

13. The person has had interaction with people having the same problem.

- External
- Undefined
- Unstable

14. The surrounding culture approves the existence of the problem.

- External
- Uncontrollable
- Stable

15. The environment in which s/he works/studies is not good.

- External
- Undefined
- Undefined

16. S/he has been suffering from a very heavy workload.

- External
- Undefined
- Undefined

17. His/her state of health and resistance of the body to germs is not good.

- Internal
- Undefined
- Undefined

18. The person is disturbed by supernatural beings.

- Undefined
- Undefined
- Unstable

19. S/he is not getting along well with her/his family.

- Undefined
- Undefined
- Undefined

20. S/he is not getting along well with her/his friends and/or colleagues.

- Undefined
- Undefined
- Undefined

21. The person lacks willpower (i.e. s/he is not a tough person).

- Internal
- Undefined
- Undefined

22. The environment in which the person lives is not good.

- External
- Undefined
- Undefined

23. S/he is infected by bacteria or germs.

- Undefined
- Undefined
- Undefined.

24. S/he lacks formal education.

- Undefined
- Undefined
- Undefined

25. His/her lifestyle is different from that of a normal person (e.g. eating habits sleeping habits any peculiar habits).

- Undefined
- Controllable
- Undefined

26. S/he lacks religious beliefs.

- Undefined
- Controllable
- Stable

Attributions of Cure

1. How hard the person tries.

- Undefined
- Controllable
- Undefined

2. How much willpower (inner strength) the person has.

- Internal
- Undefined
- Stable

3. How lucky the person is.

- External
- Uncontrollable
- Unstable

4. Whether the person gets professional help.

- External
- Controllable
- Undefined

5. The person's general ability to overcome problems.

- Internal
- Undefined
- Undefined

6. How much information the person has about the problem.

- Undefined
- Undefined
- Undefined

7. Whether the problem is a symptom of some other deep-rooted problem.

- Undefined
- Undefined
- Undefined

8. Whether the person believes it is possible to eliminate the problem.

- Internal
- Controllable
- Undefined

9. How embarrassed the person feels about having the problem.

- Internal
- Undefined
- Unstable

10. How damaging the problem is to the person's feelings of self worth or self esteem.

- Undefined
- Undefined
- Undefined

11. How much eliminating the problem would please others.

- External
- Uncontrollable
- Undefined

12. How much a person stays away from situations that make the problem worse.

- Internal
- Controllable
- Unstable

13. How much the person understands about the underlying reasons for the problem.

- Undefined
- Undefined
- Undefined

14. How much self-control the person has.

- Internal
- Undefined
- Undefined

15. Whether the person gets help from other people (friends and loved ones).

- External
- Undefined
- Undefined

16. How intelligent the person is.

- Internal
- Uncontrollable
- Stable

17. How much the person believes in God.

- Undefined
- Controllable
- Stable

18. How much the person stays away from people with similar problems.

- Undefined
- Controllable
- Unstable

19. Whether there is something wrong with the person's brain or nervous system.

- Internal
- Uncontrollable
- Stable

20. Whether the person's mother and/or father have a similar problem.

- External
- Uncontrollable
- Stable

21. Whether the person seeks out trained medical/psychological professionals.

- Undefined
- Controllable
- Undefined

22. How much the person really wants to get better.

- Undefined
- Undefined
- Undefined

23. Whether the person joins other self help groups for this problem.

- External
- Controllable
- Undefined

24. How much courage a person has to change his/her lifestyle.

- Undefined
- Controllable
- Undefined

25. How much power of recovering from psychological disturbances the person has.

- Undefined
- Undefined
- Undefined

26. Whether the person has participated in certain religious rites (e.g. worship in a Temple pray in a church or ask for advice from a fortune teller).

- Undefined
- Controllable
- Undefined

27. How much psychological support the person can get from friends or colleagues.

- External
- Undefined
- Unstable

28. Whether s/he has changed the frequency of contact with the mass media.

- External
- Controllable
- Undefined

29. How much power to recover from diseases the person's body has.

- Undefined
- Undefined
- Undefined

30. How much the environment in which the person works/studies has been improved.

- External
- Uncontrollable
- Unstable

31. How much his/her life quality can be improved (i.e. material life).

- External
- Undefined
- Undefined

32. How much the workload the person suffered can be reduced.

- External
- Undefined
- Undefined

33. How much formal education in school the person has had.

- External
- Undefined
- Undefined

34. Whether the person would be punished by the laws because of this problem.

- External
- Uncontrollable
- Stable

35. How much psychological support the person can get from family.

- External
- Undefined
- Undefined

36. How much the environment in which the person lives has been improved.

- External
- Uncontrollable
- Undefined

In sum, the expert panel agreed on the nature of only six of the twenty six cause attributions, in relation to all three dimensions of Weiner's attributional framework. Similarly, seven of the thirty six cure attributions received agreement from all five judges on all dimensions. Judges' ratings showed agreement on two dimensions with respect to three of the cause attributions and twelve of the cure attributions. The remaining attributions were rated consistently on one, or none of the dimensions. As mentioned above this proportion of disagreement is substantial. The discussion section will address possible reasons for these results and potential implications for the research.

Results of Overall Ratings

The average number of ratings for individual attributions was 336. This number reflects the fact that each of the 112 subjects rated attributions for three separate problems. An examination of the distributions of mean scores between categories revealed some very divergent patterns. Subjects' ratings within the Antisocial behaviour problem

category were, in some cases, inversely related to corresponding attributions within the Adult pathological and Child pathological categories. In other words, attributions rated at one extreme within one category were rated at the opposite extreme in one or both of the others. Therefore, the interpretative value of some of the overall ratings must be viewed as questionable. The data when collapsed across problems may not accurately reflect the complexity of the ratings as they would be seen on a category by category or problem by problem basis.

The standard deviations of the two distributions were only negligibly different (1.51 for the causes versus 1.31 for the cures). However, the overall mean score for the cause attributions was 3.84, and that for the cure attributions was 4.95. This suggests that subjects were slightly more conservative, overall, in their rating of attributions of cause compared with their ratings of attributions of cure.

In terms of the overall mean ratings of the cause attributions (see table 4 p. 148), subjects did not rate any as 'important' causes of all problems (i.e., means for individual attributions were all less than one standard deviation above the grand mean for causes). This finding, as mentioned above, may have been the result of some of the opposing ratings of the same attribution numerically cancelling each other out. The three rated as most important overall, however, were, in order from highest to lowest (Note: the English translation of the attribution is given and its mean rating follows it in brackets):

- His/her past experience (e.g., upbringing) is different from that of normal people (5.29)

- The problem is caused by some other deep-rooted problem (4.93)
- The problem is caused by the person's genetic disposition (4.77).

In the same context, two cause attributions were rated as 'unimportant' for all of the problems:

- The person is disturbed by supernatural beings (1.41)
- The person is unlucky or predestined to have the problem (1.89).

An examination of the overall mean ratings for cure attributions (see table 8, p. 153) revealed that subjects perceived five attributions as important in overcoming all problems:

- How much willpower (inner strength) the person has (6.52)
- How hard the person tries (6.48)
- Whether the person gets help from other people (friends and loved ones) (6.41)
- How much self-control the person has (6.30)
- How much courage a person has to change his/her lifestyle (6.28).

Attributions that subjects rated as relatively unimportant to overcoming all problems were:

- How much the person believes in God (2.66)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (3.14)

- How lucky the person is (3.31)
- Whether there is something wrong with the person's brain or nervous system (3.47)
- Whether the person would be punished by the laws because of this problem (3.51)
- How intelligent the person is (3.63).

Results by Problem

NB: For the analysis of the results by problem, means for each attribution were scored against either the grand mean for causes or the grand mean for the cures. With respect to this analysis, there were an average of 22 subjects who rated each attribution for each problem. As mentioned above, in order to be considered as having been rated as 'important', the mean for an attribution had to be more than one standard deviation above the grand mean. In order to be considered as having been rated as 'unimportant', the mean for an attribution had to be more than one standard deviation below the grand mean.

Compulsive Gambling

Subjects perceived four attributions to be important causes of compulsive gambling (see table 5 p. 149)

- The person lacks willpower (i.e., s/he is not a tough person) (6.73)
- The person has had interaction with people having the same problem (6.45)
- The person lacks correct information about the problem (5.77)
- The surrounding culture approves the existence of the problem (5.73).

The four attributions that subjects perceived as unimportant in causing compulsive gambling were:

- S/he is infected by bacteria or germs (0.75)
- The person is disturbed by supernatural beings (1.14)
- The problem is caused by the person's genetic disposition (1.77)
- His/her state of health and resistance of the body to germs is not good (1.91)

Mean ratings of cures (see table 9, p. 155) indicated that subjects believed four attributions to be important in overcoming compulsive gambling:

- How much willpower (inner strength) the person has (7.05)
- How hard the person tries (6.86)
- How much courage a person has to change his/her lifestyle (6.73)
- How much self-control the person has (6.55).

In terms of overcoming compulsive gambling, subjects believed that six attributions were relatively unimportant:

- Whether there is something wrong with the person's brain or nervous system (1.52);
- How lucky the person is (2.67)
- How much power to recover from diseases the person's body has (3.00)
- How intelligent the person is (3.29)

- Whether the person seeks out trained medical/psychological professionals (3.38)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (3.59)

Child Abuse

The mean ratings of the causal attributions for child abuse (see table 5 p. 149) indicate that eight were perceived as important. Contributors that subjects rated in the important range were:

- His/her past experience (e.g., upbringing) is different from that of normal people (7.04)
- The surrounding culture approves the existence of the problem (6.70)
- The law does not proscribe the problem (6.13)
- The person lacks correct information about the problem (6.04)
- The problem is caused by some other deep-rooted problem (5.71)
- S/he lacks formal education (5.63)
- S/he is not getting along well with her/his family (5.48)
- S/he is not getting along well with her/his friends and/or colleagues (5.38).

Subjects perceived three attributions as being unimportant in causing child abuse:

- S/he is infected by bacteria or germs (1.58)

- The person is disturbed by supernatural beings (1.71)
- The person is unlucky or predestined to have the problem (1.91).

Again, subjects perceived a significant number (11) of attributions as important to overcoming the tendency to abuse children (see table 9, p. 155). In fact, this problem received some of the most consistently high mean ratings of the cure attributions, as follows:

- How much self-control the person has (7.42)
- How much the person really wants to get better (7.17)
- How hard the person tries (7.04)
- How much courage a person has to change his/her lifestyle (6.92)
- How much willpower (inner strength) the person has (6.88)
- Whether the person gets help from other people (friends and loved ones) (6.75)
- How much the person understands about the underlying reasons for the problem (6.68)
- Whether the person seeks out trained medical/psychological professionals (6.67)
- Whether the person gets professional help (6.58)
- How much psychological support the person can get from family (6.50)
- Whether the person would be punished by the laws because of this problem (6.39).

In contrast, subjects ruled out only two cures as effective in overcoming the problem of child abuse:

- How lucky the person is (2.70)
- How much the person believes in God (3.14)

Social Apathy

The two attributions perceived as important causal agents (see table 5 p. 149) of social apathy were:

- The person lacks correct information about the problem (6.29)
- His/her past experience (e.g., upbringing) is different from that of normal people (5.38)

Subjects believed that four causal attributions bore little relevance to the problem of social apathy:

- S/he is infected by bacteria or germs (1.10)
- The person is disturbed by supernatural beings (1.14)
- The law does not proscribe the problem (1.67)
- There is something wrong with the person's brain or nervous system (2.00).

The mean ratings for cure attributions (see table 9, p. 155) indicated that subjects perceived only two contributors as important in overcoming social apathy:

- How hard the person tries (6.86)
- Whether the person gets help from other people (friends and loved ones) (6.55)

On the other hand, subjects rated ten attributions as unimportant in overcoming social apathy:

- How much the person believes in God (1.48)
- Whether there is something wrong with the person's brain or nervous system (1.67)
- Whether the person would be punished by the laws because of this problem (2.35)
- How lucky the person is (2.62)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (2.62)
- Whether the person seeks out trained medical/psychological professionals (2.90)
- How intelligent the person is (3.10)
- How much the environment in which the person lives has been improved (3.10)
- How much the person stays away from people with similar problems (3.14)
- How much power to recover from diseases the person's body has (3.62)

Using the Back Door (Corruption)

With respect to using the back door (corruption) it is interesting to note that this was the only problem for which more than one subject offered additional comments. In

this context, four subjects commented that they did not conceptualise corruption as a necessarily deviant behaviour. Instead, all four indicated that using the back door is, in some instances, the only way to achieve certain objectives. In relation to this problem, subjects rated five causes as important (see table 5 p. 149):

- The surrounding culture approves the existence of the problem (7.73)
- The law does not proscribe the problem (6.62)
- The person has had interaction with people having the same problem (6.50)
- The problem is caused by some other deep-rooted problem (5.74)
- Traditional background approves the existence of the problem (5.48).

Subjects viewed eight causal attributions as unimportant to the problem of corruption:

- S/he is infected by bacteria or germs (0.82)
- The person is disturbed by supernatural beings (1.09)
- The person is unlucky or predestined to have the problem (1.47)
- There is something wrong with the person's brain or nervous system (1.91)
- His/her lifestyle is different from that of a normal person (e.g., eating habits, sleeping habits, any peculiar habits) (1.95)
- The problem is caused by the person's genetic disposition (2.09)

- S/he is not getting along well with her/his family (2.14)

Interestingly, only one attribution was rated as important in overcoming corruption (see table 9, p. 155):

- Whether the person would be punished by the laws because of this problem (6.67)

Conversely, nine contributors were seen as unimportant to overcoming the problem of using the back door:

- Whether there is something wrong with the person's brain or nervous system (2.09)
- Whether the person's mother and/or father have a similar problem (2.23)
- How much the person believes in God (2.68)
- Whether the person seeks out trained medical/psychological professionals (2.82)
- How intelligent the person is (3.00)
- How lucky the person is (3.19)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (3.41)
- Whether the person joins other self help groups for this problem (3.41)
- How much power to recover from diseases the person's body has (3.48).

Lack of Civic Responsibility

The five attributions rated as important causes of lack of civic responsibility were (see table 5 p. 149):

- The surrounding culture approves the existence of the problem (7.09)
- The person lacks correct information about the problem (6.74)
- The law does not proscribe the problem (5.82)
- His/her past experience (e.g., upbringing) is different from that of normal people (5.61)
- S/he lacks formal education (5.43)

Subjects rated six attributions as contributing little to the causality of this problem

- The person is disturbed by supernatural beings (0.74)
- The person is unlucky or predestined to have the problem (1.13)
- The problem is caused by the person's genetic disposition (1.22)
- His/her state of health and resistance of the body to germs is not good (1.91)
- S/he is not getting along well with her/his friends and/or colleagues (2.26)

With respect to overcoming lack of civic responsibility (see table 9, p. 155), subjects perceived three attributions as important:

- How hard the person tries (7.13)

- How much willpower (inner strength) the person has (6.61)
- How damaging the problem is to the person's feelings of self worth or self esteem (6.57)

Seven attributions were discounted as helpful in overcoming lack of civic responsibility:

- How lucky the person is (2.26)
- How intelligent the person is (2.74)
- How much the person believes in God (3.00)
- Whether there is something wrong with the person's brain or nervous system (3.22)
- How much information the person has about the problem (3.48)
- How much the workload the person suffered can be reduced (3.57)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (3.61).

Shen-Kuei

The adult pathological problems presented a somewhat different set of beliefs regarding cause and cure. In terms of Shen-Kuei syndrome, subjects rated three attributions as important causes (see table 6, p. 150):

- The problem is caused by the person's genetic disposition (6.23)

- His/her state of health and resistance of the body to germs is not good (5.95)
- S/he is infected by bacteria or germs (5.64)

Four attributions were seen as unimportant in causing Shen-Kuei:

- The person is disturbed by supernatural beings (1.18)
- The law does not proscribe the problem (1.23)
- S/he lacks religious beliefs (1.27)
- The person is unlucky or predestined to have the problem (1.82)

Examining the mean ratings of attributions of cures for Shen-kuei, subjects viewed four as important and eight as unimportant (see table 10, p. 157). Contributors rated as important in overcoming Shen-kuei syndrome were:

- Whether the person gets help from other people (friends and loved ones) (6.67)
- How much psychological support the person can get from family (6.50)
- Whether the person gets professional help (6.41)
- How hard the person tries (6.36).

Eight attributions were viewed as unimportant in overcoming Shen-kuei syndrome:

- Whether there is something wrong with the person's brain or nervous system (1.57)
- How much the person stays away from people with similar problems (2.09)
- Whether the person would be punished by the laws because of this problem (2.19)

- How much the person believes in God (2.23)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (2.77)
- How intelligent the person is (3.05)
- How much formal education in school the person has had (3.45)
- How lucky the person is (3.64)

Neurasthenia

Beliefs surrounding the causal structure of neurasthenia suggest that it is perceived as being a complex disorder. Subjects rated seven attributions as significant aetiological factors (see table 6, p. 150):

- S/he has been suffering from a very heavy workload (7.42)
- His/her state of health and resistance of the body to germs is not good (6.48)
- The problem is caused by the person's genetic disposition (6.13)
- S/he is not getting along well with her/his friends and/or colleagues (5.88)
- S/he is not getting along well with her/his family (5.79)
- The person lacks willpower (i.e., s/he is not a tough person) (5.63)
- The environment in which s/he works/studies is not good (5.58).

Three attributions were viewed as irrelevant to the causation of neurasthenia:

- The law does not proscribe the problem (0.38)
- The person is unlucky or predestined to have the problem (1.62)
- The surrounding culture approves the existence of the problem (2.04).

In line with the aetiological complexity of neurasthenia, subjects rated eight contributors as important to overcoming the disorder (see table 10, p. 157):

- How much the person really wants to get better (6.38)
- How much power of recovering from psychological disturbances the person has (6.79)
- Whether the person seeks out trained medical/psychological professionals (6.78)
- How much self-control the person has (6.65)
- How much willpower (inner strength) the person has (6.65)
- How much courage a person has to change his/her lifestyle (6.54)
- Whether the person gets professional help (6.50)
- How much the workload the person suffered can be reduced (6.30).

A constellation of cure attributions similar to those for Shen-kuei, were rated as irrelevant to overcoming neurasthenia:

- Whether the person would be punished by the laws because of this problem (1.79)
- How much eliminating the problem would please others (2.95)
- How intelligent the person is (3.04)

- How much the person stays away from people with similar problems (3.08)
- How much formal education in school the person has had (3.25)
- How much the person believes in God (3.33)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (3.58)

Agoraphobia

Subjects rated three contributors as important in causing agoraphobia (see table 6, p. 150):

- His/her past experience (e.g., upbringing) is different from that of normal people (5.90)
- The person lacks willpower (i.e., s/he is not a tough person) (5.57)
- The problem is caused by the person's genetic disposition (5.52).

The five attributions considered unimportant in the causal scheme of agoraphobia were:

- The law does not proscribe the problem (0.62)
- The person is unlucky or predestined to have the problem (1.80)
- S/he is infected by bacteria or germs (1.86)
- The person is disturbed by supernatural beings (2.05)

- S/he lacks religious beliefs (2.24)

The following six attributions were rated as important factors in overcoming agoraphobia (see table 10, p. 157):

- How much willpower (inner strength) the person has (6.76)
- How much courage a person has to change his/her lifestyle (6.55)
- How much the person understands about the underlying reasons for the problem (6.52)
- How much self-control the person has (6.50)
- How hard the person tries (6.33)
- Whether the person believes it is possible to eliminate the problem (6.29)

The six attributions that were considered as unimportant to overcoming agoraphobia were:

- Whether the person would be punished by the laws because of this problem (2.00)
- How much the person believes in God (2.29)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (2.48)
- Whether there is something wrong with the person's brain or nervous system (3.24)
- How lucky the person is (3.52)

- How much the person stays away from people with similar problems (3.62)

Anorexia Nervosa

Subjects rated five attributions as important causes of anorexia nervosa (see table 6, p. 150):

- His/her lifestyle is different from that of a normal person (e.g., eating habits, sleeping habits, any peculiar habits) (6.00)
- His/her state of health and resistance of the body to germs is not good (5.90)
- The person lacks willpower (i.e., s/he is not a tough person) (5.76)
- The person lacks correct information about the problem (5.48)
- S/he is infected by bacteria or germs (5.38)

Four attributions were considered irrelevant as causes of anorexia nervosa:

- The person is disturbed by supernatural beings (1.57)
- The law does not proscribe the problem (1.75)
- The person is unlucky or predestined to have the problem (2.05)
- S/he lacks religious beliefs (2.24)

In terms of overcoming anorexia nervosa subjects rated eight attributions as important (see table 10, p. 157):

- How much the person really wants to get better (7.24)

- How much self-control the person has (6.95)
- Whether the person believes it is possible to eliminate the problem (6.95)
- Whether the person gets help from other people (friends and loved ones) (6.86)
- How much willpower (inner strength) the person has (6.76)
- How hard the person tries (6.67)
- How much courage a person has to change his/her lifestyle (6.43)
- How much power of recovering from psychological disturbances the person has (6.38).

Five cure attributions were perceived to be unimportant in overcoming anorexia nervosa:

- How much the person believes in God (1.95)
- How lucky the person is (2.40)
- How intelligent the person is (2.57)
- Whether the person would be punished by the laws because of this problem (2.76)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (2.81)

Schizophrenia

An examination of the mean ratings of causal attributions for schizophrenia, revealed that subjects rated six attributions as important causes of this disorder (see table 6, p. 150):

- The problem is caused by the person's genetic disposition (7.43)
- There is something wrong with the person's brain or nervous system (6.43)
- S/he has been suffering from a very heavy workload (6.43)
- His/her past experience (e.g., upbringing) is different from that of normal people (5.65)
- The problem is caused by some other deep-rooted problem (5.59)
- His/her state of health and resistance of the body to germs is not good (5.52).

Four cause attributions were rated as unimportant in terms of schizophrenia:

- The law does not proscribe the problem (1.17)
- S/he lacks religious beliefs (2.09)
- The person is unlucky or predestined to have the problem (2.14)
- The person has had interaction with people having the same problem (2.26)

The seven attributions of cures, however, emphasised external support as the most important mode of amelioration for schizophrenia (see table 10, p. 157):

- Whether the person gets help from other people (friends and loved ones) (7.61)
- Whether the person seeks out trained medical/psychological professionals (7.00)
- Whether the person gets professional help (6.95)
- How much psychological support the person can get from family (6.61)
- Whether the person's mother and/or father have a similar problem (6.48)
- How much power of recovering from psychological disturbances the person has (6.35)
- How much psychological support the person can get from friends or colleagues (6.26)

Five attributions of cure were perceived as unimportant in overcoming schizophrenia:

- Whether the person would be punished by the laws because of this problem (1.09)
- How much the person stays away from people with similar problems (2.22)
- How much the person believes in God (2.59)
- How intelligent the person is (2.91)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (3.04)

Mental Retardation

For mental retardation subjects rated two causal attributions as important and five as unimportant (see table 7, p. 151). The attributions rated as important were:

- The problem is caused by the person's genetic disposition (7.82)
- His/her past experience (e.g., upbringing) is different from that of normal people (5.59).

With respect to mental retardation, unimportant ratings were assigned to the following causal attributions:

- The person is disturbed by supernatural beings (1.14)
- The person lacks social prestige and high status (1.59)
- The person is unlucky or predestined to have the problem (1.81)
- The law does not proscribe the problem (1.86)
- S/he lacks religious beliefs (2.18)

Examination of the mean ratings for the attributions of cures revealed that subjects perceived nine to be important and five to be unimportant factors in overcoming mental retardation (see table 11, p. 159). Cure attributions rated as important were:

- How much psychological support the person can get from family (7.14)
- How much psychological support the person can get from friends or colleagues (6.64)
- Whether the person gets help from other people (friends and loved ones) (6.62)
- How much willpower (inner strength) the person has (6.45)
- The person's general ability to overcome problems (6.41)

- Whether the person seeks out trained medical/psychological professionals (6.36)
- Whether the person gets professional help (6.33)
- How much the person really wants to get better (6.32)
- Whether the person believes it is possible to eliminate the problem (6.32)

Attributions that subjects perceived as unimportant to overcoming mental retardation were:

- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (2.41)
- How much the person believes in God (2.45)
- How much the person stays away from people with similar problems (3.10)
- Whether the person would be punished by the laws because of this problem (3.32)
- How lucky the person is (3.50)

Autistic Disorder

In terms of autistic disorder subjects rated four attributions as important and three as unimportant causes of this problem (see table 7, p. 151). Attributions rated as important causes were:

- His/her past experience (e.g., upbringing) is different from that of normal people (6.58)

- The problem is caused by the person's genetic disposition (6.29)
- S/he is not getting along well with her/his friends and/or colleagues (5.58)
- S/he is not getting along well with her/his family (5.42).

Those causal attributions perceived as unimportant in the aetiology of autistic disorder were:

- The law does not proscribe the problem (0.83)
- The person is disturbed by supernatural beings (1.54)
- S/he is infected by bacteria or germs (1.92)

Two cure attributions were perceived as important, and five as unimportant in overcoming autistic disorder (see table 11, p. 159). Those attributions that were rated as important were:

- How much psychological support the person can get from family (6.96)
- How much psychological support the person can get from friends or colleagues (6.46).

Attributions viewed as unimportant to overcoming autistic disorder were:

- Whether the person would be punished by the laws because of this problem (2.13)
- How much the person believes in God (3.00)
- How much information the person has about the problem (3.43)

- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (3.54)
- How much the person stays away from people with similar problems (3.63)

Attention-Deficit Hyperactivity Disorder

Interestingly, subjects rated only one causal attribution as important in the aetiology of ADHD (see table 7, p. 151). On the other hand, seven causes were perceived to be unimportant to this problem. The single cause rated as important was:

- The problem is caused by the person's genetic disposition (5.52).

Causal attributions that were rated as unimportant in the aetiology of ADHD were:

- The person lacks social prestige and high status (0.90)
- The law does not proscribe the problem (1.10)
- The person is disturbed by supernatural beings (1.14)
- The person is unlucky or predestined to have the problem (1.67)
- S/he lacks religious beliefs (2.05)
- S/he is infected by bacteria or germs (2.19)
- The environment in which s/he works/studies is not good (2.25)

Again, interestingly, subjects did not rate any cure attributions as important in overcoming ADHD (see table 11, p. 159). However, eight attributions were rated as being unimportant to overcoming this disorder:

- How much the person believes in God (1.00)
- Whether the person would be punished by the laws because of this problem (1.55)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (2.64)
- How intelligent the person is (2.80)
- Whether the person joins other self help groups for this problem (3.18)
- How lucky the person is (3.27)
- How much the person stays away from people with similar problems (3.27)
- Whether the problem is a symptom of some other deep-rooted problem (3.64)

Conduct Disorder

A situation opposite of that for ADHD obtained for cause attributions for conduct disorder. Subjects rated eleven causes as important, and four as unimportant for this problem (see table 7, p. 151). The causal attributions that received ratings of important were:

- His/her past experience (e.g., upbringing) is different from that of normal people (7.36)

- S/he is not getting along well with her/his family (7.05)
- The person has had interaction with people having the same problem (7.05)
- The person lacks willpower (i.e., s/he is not a tough person) (6.52)
- The surrounding culture approves the existence of the problem (6.45)
- S/he is not getting along well with her/his friends and/or colleagues (6.23)
- S/he lacks formal education (6.09)
- The person lacks correct information about the problem (5.95)
- The environment in which the person lives is not good (5.67)
- The problem is caused by some other deep-rooted problem (5.50)
- His/her quality of life is low (e.g., material life) (5.41)

Cause attributions receiving a rating of unimportant were:

- The person is disturbed by supernatural beings (0.59)
- S/he is infected by bacteria or germs (1.86)
- The person is unlucky or predestined to have the problem (2.05)
- His/her state of health and resistance of the body to germs is not good (2.23)

The same situation occurred with respect to the mean ratings of cure attributions for conduct disorder (see table 11, p. 159). Subjects rated twelve contributors as important,

and four as unimportant in overcoming this problem. Cure attributions rated as important were:

- How much courage a person has to change his/her lifestyle (7.14)
- How much the person really wants to get better (7.36)
- How much psychological support the person can get from family (7.24)
- How much willpower (inner strength) the person has (7.14)
- How much self-control the person has (7.09)
- How hard the person tries (7.09)
- Whether the person gets help from other people (friends and loved ones) (6.91)
- How damaging the problem is to the person's feelings of self worth or self esteem (6.77)
- How much psychological support the person can get from friends or colleagues (6.55)
- How much a person stays away from situations that make the problem worse (6.41)
- How much the person understands about the underlying reasons for the problem (6.41)
- The person's general ability to overcome problems (6.32).

Cure attributions that were rated as unimportant to overcoming conduct disorder were:

- How lucky the person is (3.27)
- How much the person believes in God (3.36)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (3.59)
- Whether there is something wrong with the person's brain or nervous system (3.64)

Learning Disability

Subjects rated three causal attributions as important and five as unimportant, in relation to learning disability (see table 7, p. 151). The attributions to which subjects attached causal importance were:

- The person lacks willpower (i.e., s/he is not a tough person) (5.61)
- S/he lacks the intelligence or ability to manage things (5.57)
- S/he is not getting along well with her/his family (5.52)

Subjects perceived the following causal attributions as unimportant in the aetiology of learning disorder:

- The law does not proscribe the problem (0.78)
- The person is disturbed by supernatural beings (0.78)
- S/he lacks religious beliefs (1.65)
- The person lacks social prestige and high status (1.73)

- The person is unlucky or predestined to have the problem (1.73)

Subjects were more liberal in assigning importance to curative attributions for learning disability (see table 11, p. 159). The eleven cure attributions rated as important in overcoming this problem were:

- How hard the person tries (8.17)
- How much willpower (inner strength) the person has (7.83)
- Whether the person gets help from other people (friends and loved ones) (7.39)
- How much psychological support the person can get from family (7.22)
- How much self-control the person has (6.87)
- The person's general ability to overcome problems (6.83)
- How much psychological support the person can get from friends or colleagues (6.65)
- How much courage a person has to change his/her lifestyle (6.43)
- Whether the person gets professional help (6.41)
- How damaging the problem is to the person's feelings of self worth or self esteem (6.35).
- Whether the person believes it is possible to eliminate the problem (6.32).

Subjects rated six cure attributions as unimportant to overcoming learning disability:

- How much the person believes in God (2.09)

- Whether the person would be punished by the laws because of this problem (2.26)
- Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller) (2.43)
- Whether the person's mother and/or father have a similar problem (3.32)
- How much the person stays away from people with similar problems (3.55)
- How lucky the person is (3.64)

Chapter V

Discussion and Conclusions

The Expert Ratings

The divergence of opinion, as revealed in the expert judges' ratings of the attributions, was noted earlier. In terms of both the causes and cures, there were fewer than 20 percent of the attributions on which agreement was reached with respect to all three of Weiner's dimensions. It seems likely that this was the result of one of two factors. First, although they were all PhD's in psychology, four of the five judges represented significantly different theoretical orientations. It is possible that this resulted in disparate conceptions of all but the most clearly definable attributions.

A second possibility is that the attributions were sufficiently ambiguous to preclude unanimous agreement. Knapp and Karabenick (1985) indicate that, while they used Weiner's framework as a guide in selecting the attributions for their questionnaire, there was "no intention... to restrict them to those that easily fall into that framework" (p. 348). Since their questionnaire served as the template for those used in the subsequent studies (including the instrument used in the current research), it seems likely that this second explanation for the judges' disagreement is the more valid one.

While there was significant disagreement about most of the attributions, this does not negate the usefulness of the panel's ratings for the purposes of the current research. For most of the problems studied, at least one of the attributions that subjects rated as an important cause or cure, was included among those that received unanimous panel

agreement with respect to all three of Weiner's (1980) attributional dimensions. This allowed for at least a partial analysis of the problems in terms of Weiner's framework.

If it can be assumed that the experience of a psychological problem constitutes a negative outcome or state of affairs for the sufferer, some of the implications of Weiner's attributional framework for affective and help-seeking responses include the following:

1. Attribution of cause to internal characteristics of the sufferer should lower self-esteem.
2. Attribution of cause to external factors should leave self-esteem relatively unaffected.
3. Attribution of cause to stable factors should produce a sense of helplessness and reduce motivation to seek help in overcoming the problem or to try to overcome the problem independently.
4. Attribution of cause to unstable factors should produce a sense of hopefulness and increase motivation to seek help in overcoming the problem or to try to overcome the problem independently.
5. Attribution of cause to controllable factors should produce a sense of guilt for the problem in the sufferer and possibly anger on the part of others toward the individual.
6. Attribution of cause to uncontrollable factors should produce a sense of shame for the problem in the sufferer and possibly pity on the part of others toward the individual.

Ratings by Problem

General overview

In as much as the subjects of this study represent the views of Chinese lay people, the findings are generalisable only to a point. Again, it must be cautioned that this sample

is highly selected and cannot be said to be representative of the general population of mainland China. With this caveat in mind the following discussion of the results is offered.

Of the attributions examined in the study, there were none that were consistently rated as important across all problems. In this context, however, it is interesting to note the low importance consistently ascribed to a number of attributions of cause and cure. The lowest rating consistently across all problems was given to the cause attribution 'The person is disturbed by supernatural beings'. This was followed by 'S/he lacks religious beliefs'. The last causal attribution that received consistently low ratings was 'The person is unlucky or predestined to have the problem'.

In terms of cure attributions, those receiving consistently low ratings reflected the same themes. Generally rated lowest among the cure attributions was 'How much the person believes in God'. This was followed closely by 'Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller)'. And the last cure attribution consistently given low importance ratings was 'How lucky the person is'. In this respect, the perceptions of this sample resemble those of the British (Henley & Furnham, 1988; Furnham & Henley, 1988) and American (Knapp & Karabenick, 1985) samples, slightly more than those of the Hong Kong (Luk & Bond, 1992) sample. These findings argue strongly against the popular perception that mainland Chinese attribute misfortune in the form of psychological problems to supernatural phenomena or fate.

The Antisocial Behavioural Problems.

As a blanket statement about the antisocial behavioural problems, it seems that mainland Chinese lay people believe the causes of these disorders to be beyond the individual's control. Causal attributions that were common to all of these problems, and that subjects perceived as important, were rated by the panel of judges as external, uncontrollable and stable. In terms of Weiner's attributional framework, these problems would seem to have low impact on the individual's self-esteem, absolve the individual of responsibility for the condition and reduce motivation to seek help for these problems. However, in terms of the cure attributions, the responsibility for overcoming such difficulties clearly rested with the individual. This was a paradoxical finding since, on one hand attributions for cause seem to remove the responsibility for the disorder, however, attributions for cure strongly implicate the individual.

Particularly in the case of child abuse there was a significant tendency to attribute causality to factors outside the individual's control. However, among the antisocial behavioural problems, only child abuse was perceived as necessitating professional help to overcome the problem. The cause and cure attributions for child abuse, were also unique among the antisocial behavioural disorders in the striking similarity they bore to one of the child pathological problems, conduct disorder (discussed below).

In a society that places a high premium on social harmony and actively promotes such values in its citizens, one might assume that lack of civic responsibility, social apathy and corruption would be clearly perceived by mainland Chinese lay people as deviant. Indeed, these were among the problems that, in Luk and Bond's (1992) study, were cited

by their informants as significantly disruptive problems in Hong Kong society. However, some of the attributions rated as important causes of these problems seem to argue against this assumption. Causal attributions such as 'the surrounding culture approves the existence of the problem' and 'the law does not proscribe the problem' were common to these three antisocial behavioural problems. It is also significant, as noted above, that 'using the back door' was considered as the only way to "get things done" by four of the respondents in this study.

Adult Pathological Problems

Shen-Kuei Syndrome

The general profile of beliefs in relation to the adult pathological problems presents a more interactional picture than that seen in the antisocial behavioural problems. In terms of causes, subjects seemed to perceive of Shen-kuei as strictly biologically determined. This also agrees with the findings of Luk and Bond (1992), in that the their cluster analysis of cause (and cure) attributions revealed that Shen-kuei was viewed by Hong Kong Chinese lay people as unique among the disorders. The causal attribution rated most important in relation to Shen-kuei (the person's genetic disposition) was rated by the panel as internal, uncontrollable and stable. This would imply that having the disorder would negatively impact the sufferer's self-esteem, induce feelings of shame, elicit pity from others and decrease motivation to seek help for the problem. Chinese respondents perceived an important role for social and professional support as well as commitment in the amelioration of Shen-kuei. Perhaps surprisingly, intelligence was not seen as relevant

to overcoming the disorder. This would seem to imply that it Shen-kuei is not perceived as a disorder which is limited to the unsophisticated. The combination of internal, uncontrollable and stable attributions, with the emphasis on the role of professional help in ameliorating this disorder, seems to indicate that subjects perceive this to be a relatively intractable problem.

Neurasthenia

The results of this study seemed to support the notion that Chinese hold a highly interactional view of neurasthenia and the pathological problems in general. The mean ratings of cause attributions indicated that both internal and external uncontrollable factors were implicated. Accordingly, overcoming this disorder was seen as necessitating social and professional support, but also demanded the commitment of the inner resources of the individual. This finding is consistent with that of Luk and Bond (1992) in that this type of problem was perceived to be caused by the environmental-hereditary factor and most subject to amelioration by clinical methods, while the commitment cure factor was perceived as generally important. If it can be assumed that the interaction of two opposing attributions would produce a neutral reaction, than neurasthenia should produce little change in self-esteem (locus dimension). The fact that cause attributions were primarily uncontrollable would absolve the individual of responsibility for the problem. Finally, causes rated as important to neurasthenia included both stable and unstable attributions. If the above reasoning is valid than motivation to seek help should also be relatively unaffected (i.e., neither enhanced nor diminished).

Agoraphobia

While attributing causality for agoraphobia to both internal and external factors, subjects rated only attributions reflecting internal characteristics as necessary to ameliorating the problem. Attribution to the person's genetic disposition was the only cause that the panel agreed on. It was rated as internal, uncontrollable and stable. This should produce lower self-esteem, shame about the disorder and diminished motivation to seek help. The cause rated as most important (the person's upbringing) was rated as external. Therefore, the interactional view of this disorder as found by Luk and Bond (1992) was partially supported. The fact that external support was not seen as necessary to curing agoraphobia may indicate that the problem is not perceived to be as serious as some of the disorders that require outside help, and that the individual suffering from this problem should be able to get over it on his or her own.

Anorexia nervosa

This was the only instance in which none of the attributions rated as important was among those receiving unanimous agreement from the expert panel, with respect to Weiner's three dimensions. In terms of aetiology for anorexia nervosa Chinese subjects seemed to perceive only causal explanations that were internal to the individual. However, it seemed that they perceived not only personal agency, but also outside support (friends and loved ones) as necessary to overcoming anorexia nervosa. The cure ratings were very consistent with those of Furnham and Henley's (1988) subjects, except that the subjects in this study did not endorse the role of professional help in overcoming anorexia nervosa.

Subjects in this study differed from those in the Luk and Bond (1992) study, in that they rated only internal causes as important to anorexia nervosa.

Schizophrenia

The types of aetiological factors rated as important to schizophrenia also seem to support the notion that Chinese hold an interactional view of psychological disorder. The pattern of causal attributions for schizophrenia presents the same picture, in terms of Weiner's attributional framework, as that seen in relation to Shen-kuei syndrome. The causal model held for this disorder, as with the other adult pathological conditions, is very much in agreement with the diathesis model currently embraced in the West. In terms of the more 'severe' problems (Shen-kuei, neurasthenia and schizophrenia), greater emphasis is placed on outside support to overcome them. While both internal and external factors are believed to cause such problems, it seems that Chinese believe that the primary responsibility for ameliorating these problems rests outside the sufferer.

Child Pathological Problems

Mental retardation

Mental retardation, the first of the childhood pathological problems, elicited internal and external aetiological attributions. This would seem to imply that subjects held similar, interactional beliefs about mental retardation and the 'serious' adult pathological problems (Shen-kuei syndrome, neurasthenia and schizophrenia). Concomitantly, subjects endorsed both internal and external approaches to overcoming this condition. While the cause was seen to be primarily beyond the individual's control, this was not the case for overcoming

mental retardation. It seems that for a condition that is primarily viewed by lay people in the West as intractable, Chinese respondents believed that there were avenues to lessening the detrimental effects of the disorder. Further, the Chinese endorsed the belief that the individual suffering from mental retardation could also influence his or her condition.

Autistic disorder

The causes of autistic disorder were also perceived to include both internal and external factors. Possibly as a result of the non-communicative aspect of the disorder, Chinese seemed to view this as primarily a problem of social origin. However, included among the important causes was a strong endorsement for genetic causality. Therefore, the same interpretation of the Weiner's (1980) attributional framework holds for Autistic disorder as those for the other disorders reflecting this interactional view. The principle modes of intervention endorsed by subjects were both social support oriented. This emphasis on social causality and intervention, seems to reinforce the notion of the high importance that mainland Chinese place on interpersonal harmony.

Attention-deficit hyperactivity disorder

It was remarkable that subjects endorsed only one aetiological attribution as relevant to ADHD: 'The problem is caused by the person's genetic disposition'. This may reflect one of two things. Either, this disorder is so foreign to the subjects in this sample that there was a great deal of confusion surrounding its origins. Or, all of the subjects who rated this disorder held a single strong aetiological impression for ADHD. This question is impossible to answer from the data. However, the fact that the mean for the attribution of

genetic causes in this case was only 5.52 does not seem to support the notion of strong consensus. It appears, therefore, that the individuals rating this disorder were not at all certain about its origins, for whatever reason. In terms of the ratings of the cure attributions, none were rated as important in overcoming this disorder. A mechanical error during reproduction of the questionnaires, resulted in only half of the sections that included curative ratings for ADHD being produced. Therefore, the number of subjects returning ratings for this disorder was reduced to eleven. It could be argued that this may have accounted for the attenuation of the importance ratings for cures. However, 21 subjects rated the causes of ADHD with seemingly no more consensus. Thus, the mechanical error theory does not seem to be supported. It is obvious that this anomaly warrants further investigation.

Conduct disorder

Equally remarkable was the large number of cause and cure attributions that subjects rated as important in terms of conduct disorder. To say that these subjects held an interactional perspective with respect to this disorder would be an understatement of the data. In terms of both causality and cure, all of Weiner's dimensions were represented. This raises the question of the degree to which these subjects were certain of any one cause or cure. By the same argument that subjects were reluctant to rate any of the attributions as important as cases or cures of ADHD, it could be argued that the abundance of attributions rated as important for conduct disorder also reflects significant uncertainty. This anomalous finding also warrants further investigation. It is also interesting to speculate about the reason for such a divergent finding among Chinese

subjects with regard to two disorders that are perceived in the West, at least among the clinical community, to be so intimately linked.

A final remarkable finding with regard to conduct disorder was its similarity, in terms of both cause attributions and cure attributions, to child abuse. With respect to cause attributions, subjects perceived eight to be important to child abuse and eleven were believed to be important causes of conduct disorder (primarily external stable and unstable attributions). What is remarkable about these ratings is that seven of them were perceived to be important to both disorders. This seems to indicate that, possibly due to the extreme antisocial and violent nature of both disorders, subjects strongly associated the two.

In terms of attributions of cures, these disorders shared seven common contributors. What is also notable was the fact that cure items 21 (Whether the person seeks out trained medical/psychological professionals) and 4 (Whether the person gets professional help) were considered important for overcoming child abuse but not for conduct disorder. Instead, subjects included internal stable (self control, general ability to overcome) attributions and external unstable (avoidance) as important cures for conduct disorder. It seems that subjects believed that conduct disordered children were more responsible for overcoming their problems than were adult child abusers.

Learning disability

In rating the causes and cures of learning disability subjects endorsed attributions that reflected both extremes of all three dimensions of Weiner's (1980) framework. The one causal attribution rated as important, 'S/he lacks the intelligence or ability to manage

things', was rated by the panel as internal, uncontrollable and stable. Cures for learning disability, again, included both extremes of all three dimensions. The endorsement of all forms of external help, as well as the high importance placed on inner control factors seems to imply that Chinese view this problem as more intractable than some of the other disorders.

Conclusion

A number of interesting features emerge as general trends in the data (see Appendices E and F). The wide range of mean values (0.38 to 7.82 for causes and 1.00 to 8.17 for cures) is evidence that subjects considered some attributions to be very important, while others are considered almost completely irrelevant. As mentioned above, the fact that the grand mean of the cure attributions for all problems was 1.11 points higher than that for the cause attributions, reflects the general tendency for subjects to assign higher ratings to the cures. This indicates that subjects were more comfortable in assigning stronger positive ratings to cures than to causes. The mean ratings of cause and cure attributions show significant variability both within and between problems. This indicates that different attributions are considered to be important as causes and cures of different problems.

While subjects seemed to believe that antisocial behavioural problems were caused by external forces that are beyond the individual's control, they generally expected the individual to take responsibility for overcoming these problems. With respect to both the adult and the child pathological problems, subjects presented a generally interactional view

of both causes and cures. As mentioned above, this is in line with the diathesis model of mental illness that currently enjoys wide support among many members of both the psychological and psychiatric communities in North America. It has been argued by this author, however, that this may be an artefact of the highly educated nature of the sample. In any event, the respondents in this survey may well be considered to be representative of the population of recent immigrants from the People's Republic of China.

Finally, Weiner's attributional framework seems, within a limited range, to be a valid way of categorising the various attributions that constitute lay beliefs. In particular, it was interesting to note that attributions on which all of the panel agreed were also among those rated most highly by subjects in this study. It seems that attributions that were most clearly categorised by the expert judges were also the most consistently salient to the sample of mainland Chinese lay people.

Implications for practice

It would seem that for the antisocial behavioural problems, excluding child abuse, professional help is unlikely to be sought by, or suggested to, individuals experiencing these as a way of overcoming such difficulties. It is, therefore, unlikely that the mainstream mental health worker will encounter clients seeking help for such problems as compulsive gambling unless treatment is mandated by the courts or other social agencies.

In the case of child abuse, it seems likely that mental health professionals may encounter a presentation that emphasises external and uncontrollable forces in the cause of this problem, but emphasises the importance of internal factors such as will power in

overcoming the problem. It would be useful in these instances for the therapist to innitiate exploration of the problem from this 'external' perspective and to structure intervention strategies with a view to bolstering 'internal' resourses with those of external supports such as family, friends and the mental health community.

In terms of the pathological problems it seems unlikely that the mental health professional will encounter clients with these difficulties until relatively late in the progression of the problem if at all. Due to the interactional view held with respect to both the cause and cure for the majority of these disorders, it is likely that those suffering from these problems and/or those close to them will endorse medical or social (e.g., family and/or friends) support as first choice intervention strategies. If this is true, then it is incumbent on mental health professionals to target interventions geared toward the mainland Chinese population in Edmonton into the communtiy.

There are a number of ways in which interventions can be more effectively targeted. One way this can be accomplished by having counsellors address various Chinese cultural and communtiy groups in an effort to increase the profile of 'mainstream' psychological services. Increasing awareness of available services and attempting to destigmatise psychological problems should be primary goals of this strategy.

Another approach would see mental health practitioners forming liaisons with both Western and traditional Chinese medical practitioners who serve the mainland Chinese community in an effort to work cooperatively in promoting the psychological well being of members of this population. The goal of this strategy is also twofold; to encourage more

rapid and appropriate referral of the more severely distressed clients for psychological intervention, and to enlist the aid of these professionals in the therapeutic process.

Subjects placed significant emphasis on the importance of social and familial support in ameliorating psychological problems of all types. This would seem to indicate that efforts should be targeted at involving family members in the therapeutic process as well.

Implications for research and counsellor education

The results of this study have provided some insights into the structure of mainland Chinese lay beliefs about the causes and cures of psychological problems. While the sample was limited in terms of age and level of education, it did include smaller sub-samples of older and less well educated individuals. A further analysis of the current results in terms of age and educational level could provide some interesting contrasts with respect to different belief structures held by these sub-groups. Nunnally (1961), among others, had found significant differences in the beliefs held by groups differing along these dimensions.

Further research in this area among a general population is warranted. Ideally the sample should be taken from a population more representative of the average mainland Chinese lay person.

A comparative study conducted with similarly educated 'Canadian' subjects would be beneficial as well. This would provide a more accurate index of the degree to which culture influences these belief structures, while controlling for the level of education.

Finally, it would be helpful to examine the belief structures of a clinical sample of mainland Chinese individuals experiencing these problems. It would be helpful to include an examination of help-seeking behaviour and response to various treatment modalities in relation to these beliefs, with the aim of finding more culturally appropriate and effective ways of serving this population.

The interactional view held by mainland Chinese clients has implications for the way that interventions are undertaken. Counsellors should be sensitised to examine the nature of physiological complaints that their clients may bring to the therapeutic setting. These complaints, if present, constitute a very real component of the problem picture and cannot be treated as incidental.

Therapists should learn to use physiological manifestations of distress as a tool in therapy. Questions addressing somatic complaints (e.g., when did your back pain first become a problem?) can act as a starting point to remove the focus from the psychological or interpersonal realm. The focus can gradually be shifted by asking questions associated with the somatic referant to reveal possible psychological factors that may underlie the presenting problem (e.g., what sorts of things were occuring in your personal life at the same time as the back pain began). This approach not only validates the client's world view of his or her disorder, but also enhances the therapeutic relationship and could conceivably facilitate more effective therapy.

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APPENDIX A

English Translation of Lay Beliefs Questionnaire

Dear Sir or Madam,

The Package you have just picked up contains a questionnaire and a data sheet which are part of a survey research project that constitutes the main source of data for a study on Chinese lay beliefs about psychological problems. I am undertaking this study as part of my masters thesis research.

The study is designed to determine the average mainland Chinese person's ideas about the causes and cures of psychological problems. Unlike many physical disorders for which one might take a medication and wait to get better, it is believed that the treatments for some psychological problems are influenced by peoples' beliefs associated with them. If this is true then the better we understand peoples' beliefs about psychological problems, the better able we will be to treat such problems in the future. The goal of this research project is to help to achieve a better understanding of the beliefs of average Chinese people in order to devise better approaches to helping Chinese people who suffer from some of the problems mentioned here.

Please read the material in the package carefully and complete the forms to the best of your ability. The entire process should require about 30 to 40 minutes to complete. Once you have answered all of the questions, please seal the envelope provided and send it to the researcher by mail.

The results of the study should be available by late May or early June, 1994. I will be happy to discuss them with anyone interested. I can be contacted at:

David B. Sinclair

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Thank you for your participation in this project.

The purpose of this questionnaire is to solicit the opinions of ordinary people about the different psychological problems described on the pages that follow. We want to know what you think about the causes and cures of each problem. By circling one number please rate the factors on the pages that follow according to their relative importance.

Your participation in this study is completely voluntary and you may cease to participate at any time. The information you provide is strictly confidential. In order to ensure this, please do not write your name or any other identifying information on the questionnaire. If, as a result of your participation in the project, you have any questions or concerns, or if you feel uncomfortable in any way, please contact me at the above noted address or telephone number and I will answer any questions and arrange for any other assistance you wish.

For the purpose of the research, please provide the following personal information on this page. Please put a check mark (√) in the appropriate places on the form below.

Sex:	Male__	Female__		
Age:	20 or under__	21 - 30 yrs.__	31 - 40 yrs.__	41 - 50 yrs.__
	51 - 60 yrs.__	61 - 70 yrs.__	Over 70 yrs.__	
Education:	Elementary__	Jr. High__	High School__	College__
	Undergrad.__	Masters__	PhD__	
Occupational:	Part-time__	Full-time__	Moonlighting_	Unemployed__
	Retired__	Student__		
Marrital:	Single__	Married__	Separated__	Divorced__
	Other__			
Birthplace:	Rural__	Urban__		
Region:	North__	South__		
Outside China:	1 yr. or less__	1 - 2 yrs.__	3 - 5 yrs.__	6 - 10 yrs.__
	11 - 20 yrs.__	20 or more__		

(A brief description of the particular disorder to be rated is inserted here)

Following are some possible factors that might cause a person to have this problem.

Factors:	Unimportant									Important
1. The problem is caused by the person's genetic disposition.	0	1	2	3	4	5	6	7	8	9
2. The law does not proscribe the problem.	0	1	2	3	4	5	6	7	8	9
3. The person lacks social prestige and high status.	0	1	2	3	4	5	6	7	8	9
4. The person lacks correct information about the problem.	0	1	2	3	4	5	6	7	8	9
5. The problem is caused by some other deep-rooted problem.	0	1	2	3	4	5	6	7	8	9
6. The person is unlucky or predestined to have the problem.	0	1	2	3	4	5	6	7	8	9
7. Traditional background approves the existence of the problem.	0	1	2	3	4	5	6	7	8	9
8. There is something wrong with the person's brain or nervous system.	0	1	2	3	4	5	6	7	8	9
9. His/her quality of life is low (e.g., material life).	0	1	2	3	4	5	6	7	8	9
10. S/he lacks the intelligence or ability to manage things.	0	1	2	3	4	5	6	7	8	9
11. His/her past experience (e.g., upbringing) is different from that of normal people.	0	1	2	3	4	5	6	7	8	9
12. S/he has very frequent contact with the mass media (e.g., watching TV or reading periodicals).	0	1	2	3	4	5	6	7	8	9
13. The person has had interaction with people having the same problem.	0	1	2	3	4	5	6	7	8	9
14. The surrounding culture approves the existence of the problem.	0	1	2	3	4	5	6	7	8	9
15. The environment in which s/he works/studies is not good.	0	1	2	3	4	5	6	7	8	9
16. S/he has been suffering from a very heavy workload.	0	1	2	3	4	5	6	7	8	9
17. His/her state of health and resistance of the body to germs is not good.	0	1	2	3	4	5	6	7	8	9
18. The person is disturbed by supernatural beings.	0	1	2	3	4	5	6	7	8	9
19. S/he is not getting along well with her/his family.	0	1	2	3	4	5	6	7	8	9
20. S/he is not getting along well with her/his friends and/or colleagues.										

	0	1	2	3	4	5	6	7	8	9
21. The person lacks willpower (i.e., s/he is not a tough person).	0	1	2	3	4	5	6	7	8	9
22. The environment in which the person lives is not good.	0	1	2	3	4	5	6	7	8	9
23. S/he is infected by bacteria or germs.	0	1	2	3	4	5	6	7	8	9
24. S/he lacks formal education.	0	1	2	3	4	5	6	7	8	9
25. His/her lifestyle is different from that of a normal person (e.g., eating habits, sleeping habits, any peculiar habits).	0	1	2	3	4	5	6	7	8	9
26. S/he lacks religious beliefs.	0	1	2	3	4	5	6	7	8	9

Please list here any additional causal factors you feel are important to our understanding of this problem.

_____

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Following are some possible important factors that might influence a person in getting over this disorder.

Factors:	Unimportant									Important
1. How hard the person tries.	0	1	2	3	4	5	6	7	8	9
2. How much willpower (inner strength) the person has.	0	1	2	3	4	5	6	7	8	9
3. How lucky the person is.	0	1	2	3	4	5	6	7	8	9
4. Whether the person gets professional help.	0	1	2	3	4	5	6	7	8	9
5. The person's general ability to overcome problems.	0	1	2	3	4	5	6	7	8	9
6. How much information the person has about the problem.	0	1	2	3	4	5	6	7	8	9
7. Whether the problem is a symptom of some other deep-rooted problem.	0	1	2	3	4	5	6	7	8	9
8. Whether the person believes it is possible to eliminate the problem.	0	1	2	3	4	5	6	7	8	9
9. How embarrassed the person feels about having the problem.	0	1	2	3	4	5	6	7	8	9
10. How damaging the problem is to the person's feelings of self worth or self esteem.	0	1	2	3	4	5	6	7	8	9
11. How much eliminating the problem would please others.	0	1	2	3	4	5	6	7	8	9
12. How much a person stays away from situations that make the problem worse.	0	1	2	3	4	5	6	7	8	9
13. How much the person understands about the underlying reasons for the problem.	0	1	2	3	4	5	6	7	8	9
14. How much self-control the person has.	0	1	2	3	4	5	6	7	8	9
15. Whether the person gets help from other people (friends and loved ones).	0	1	2	3	4	5	6	7	8	9
16. How intelligent the person is.	0	1	2	3	4	5	6	7	8	9
17. How much the person believes in God.	0	1	2	3	4	5	6	7	8	9
18. How much the person stays away from people with similar problems.	0	1	2	3	4	5	6	7	8	9
19. Whether there is something wrong with the person's brain or nervous system.	0	1	2	3	4	5	6	7	8	9
20. Whether the person's mother and/or father have a similar problem.	0	1	2	3	4	5	6	7	8	9
21. Whether the person seeks out trained medical/psychological professionals.	0	1	2	3	4	5	6	7	8	9
22. How much the person really wants to get										

better.	0	1	2	3	4	5	6	7	8	9
23. Whether the person joins other self help groups for this problem.	0	1	2	3	4	5	6	7	8	9
24. How much courage a person has to change his/her lifestyle.	0	1	2	3	4	5	6	7	8	9
25. How much power of recovering from psychological disturbances the person has.	0	1	2	3	4	5	6	7	8	9
26. Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller).	0	1	2	3	4	5	6	7	8	9
27. How much psychological support the person can get from friends or colleagues.	0	1	2	3	4	5	6	7	8	9
28. Whether s/he has changed the frequency of contact with the mass media.	0	1	2	3	4	5	6	7	8	9
29. How much power to recover from diseases the person's body has.	0	1	2	3	4	5	6	7	8	9
30. How much the environment in which the person works/studies has been improved.	0	1	2	3	4	5	6	7	8	9
32. How much the workload the person suffered can be reduced.	0	1	2	3	4	5	6	7	8	9
33. How much formal education in school the person has had.	0	1	2	3	4	5	6	7	8	9
34. Whether the person would be punished by the laws because of this problem.	0	1	2	3	4	5	6	7	8	9
35. How much psychological support the person can get from family.	0	1	2	3	4	5	6	7	8	9
36. How much the environment in which the person lives has been improved.	0	1	2	3	4	5	6	7	8	9

Please list here any additional curative factors you feel are important to our understanding of this problem.

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Description of disorder of reference

1. Compulsive Gambling: This is a kind of addictive behaviour. The individual gambles habitually. (Even when they constantly loose money, they continue to gamble).

2. Child Abuse: Parents abuse their offspring so that their actions result in physical, emotional or psychological damage. Generally speaking physical punishment could cause psychological trauma.

3. Social Apathy: Generally uncooperative and non-altruistic behaviour. Unconcerned about the welfare or rights of others. Self absorbed - only concerned about self. (e.g., [Chinese saying] you only shovel the snow on your walk and do not care if others' homes are covered in frost.) This phenomenon has the implication of selfishness and not troubling one's self on behalf of others.

4. Using the Back Door (corruption): A kind of illegal behaviour. The person makes use of private personal relationships or money to achieve certain goals. This kind of behaviour can destroy the normal functioning of an institution and is commonly called 'bribery' or 'corruption'.

5. Lack of Civic Responsibility: A type of behaviour that contravenes social conventions and damages public property. Some behaviours are done purposefully and some are just bad habits (e.g., spitting or littering).

6. Shen-kwei ('vital or kidney deficiency'): A form of male disorder for which symptoms include sexual impotence, urinary inhibition, kidney inefficiency and generalised weakness.

7. Neurasthenia: A psychological/mental disorder. Symptoms include insomnia, anxiety, emotional instability, physical weakness and being easily fatigued.

8. Agoraphobia: When the individual goes out in public places, open spaces or leaves his/her dwelling they experience an extreme sense of fear including symptoms such as cold sweat, heart palpitations and sense of panic.

9. Anorexia Nervosa: This is a type of eating disorder. The patient displays an aversion to eating food or a tendency to vomit shortly after consumption of food. This results in severe malnutrition, extreme weight loss and endangers their lives.

10. Schizophrenia: This includes a group of mental disorders that are commonly known as: craziness, madness etc. The characteristics of the disorder is that the patient displays disordered thinking, emotions and behaviour. The obvious symptoms include illogical thinking, incoherent ideas, lack of accurate sensation and concentration, hallucinations and illusions, flat emotion, inappropriate emotional responses, detachment from social reality and occasionally bizarre physical posture and/or movement.

11. Mental Retardation: This disorder is diagnosed in childhood. It is marked by very low IQ which limits the child's ability to learn academically and general level of functioning in the areas of life and social skills.

12. Autistic Disorder: This disorder is diagnosed in childhood. Symptoms include things such as lack of awareness of the existence or feelings of others. Little or no comfort seeking behaviour (e.g., if ill, hurt or frightened does not seek out parent for comfort) and very limited or no social interaction. Little or no communication including spoken language or facial expressions. When speech is present it may be strange or mechanical conveying little or no meaning.

13. Attention-Deficit Hyperactivity Disorder: This disorder is diagnosed in childhood. Symptoms include inability to sit still for any period of time, easily distracted, excessive talking and inability to maintain attention during tasks or play.

14. Conduct Disorder: This disorder is diagnosed in childhood. Symptoms include serious repeated occurrences of some of the following: stealing, lying, fighting, deliberately starting fires, running away from home, torturing animals, assaulting others and little or no respect for authority.

15. Learning Disability: This disorder is diagnosed in childhood. Consistently low scores on either standardised achievement tests or in school in the areas of math or language arts despite evidence of sufficiently high intelligence (IQ), and in the absence of any visual, auditory or other

physical impairment.

APPENDIX B

Chinese Version of Lay Beliefs Questionnaire

亲爱的女士们,先生们：

您所收到的是一份有关中国人对精神疾患观念的问卷，作为我的硕士研究论文的一部分，本问卷是要了解一般中国人对精神疾患的起因和治疗的看法。

对于许多生理疾患，人们通常服用一些药物而待其恢复。但对于精神疾患一般认为治疗的方法是受到人们对其认识的影响。如果确实如此的话，那么我们了解人们对精神疾患的看法越多，将越有助于对精神疾患的治疗。本研究的目的是希望能够更好地了解一般中国人对精神疾患的认识，以便能够找出更好的途径来帮助那些患有各种精神障碍的中国人。

请您认真地阅读所提供的材料，同时回答问卷中的每一个问题。完成问卷以后，请将其装入所提供的信封内，并希望您能在十天内寄回给我。参加本项研究是以志愿的原则为基础的，所以您可以在任何时间中止参与这项研究。此项研究将于今年五月底或六月初完成，您若有兴趣我将会很高兴与您讨论研究的结果。您可以通过以下地址与我联系。

David Sinclair,
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University of Alberta,
Edmonton, Alberta.
T6G-2G5
Ph 492-5245

非常感谢您的合作。

大卫 辛克磊

这份问卷的目的，是研究一般人对以下三种精神疾患问题的看法。我们想知道，你认为这些问题有什么成因以及治疗方法；请根据列出的各个因素的重要程度，圈出一个数字。在填写时请不要与他人商量，我们希望知道的是您个人的看法。请回答所有的问题而不要跳过任何一个，问卷的填写对于本研究至关重要，如果您对任何一个项目不是十分肯定，也请画出您自认为最适当的数字。请注意这里并没有正确与错误的答案之分。
如果因为参加这项研究活动，您有什么问题或任何不舒服的心里感觉，请您用上面的地址或电话随时与我联系。

为了研究目的，请填写以下的个人资料在适当空格内画上“X“。所有个人资料绝对保密。请不要在卷中写下您的姓名。

性别：	男___	女___		
年龄：	少於20___	21-30___	31-40___	41-50___
	51-60___	61-70___	大过70___	
教育程度：	小学___	中学___	高中___	大专___
	大学___	硕士___	博士___	
就业情况：	全职___	临时工___	兼职___	失业___
	退休___	学生___		
婚姻状况：	未婚___	已婚___	分居___	离婚___
	其他___			
出生地点：	农村___	城市___		
来自：	南方人___	北方人___		
住国外时间：	少於一年___	1-2___	3-5___	6-10___
	11-20___	20年以上___		

(Insert description of disorder to be rated)

以下是可能导致一个人患上这问题的因素：

因素	完全不重要（不能导致）									非常重要（能够导致）
1. 这个人的先天遗传倾向	0	1	2	3	4	5	6	7	8	9
2. 法律没有加以禁止	0	1	2	3	4	5	6	7	8	9
3. 他是否欠缺社会地位和声望	0	1	2	3	4	5	6	7	8	9
4. 他对这问题是否缺之正确的认识	0	1	2	3	4	5	6	7	8	9
5. 这问题能否由另一潜伏更深的问题所引发	0	1	2	3	4	5	6	7	8	9
6. 他是否命中注定或注定倒霉	0	1	2	3	4	5	6	7	8	9
7. 他的传统背景是否认可这问题的存在	0	1	2	3	4	5	6	7	8	9
8. 他的脑部或神经系统是否连作失常	0	1	2	3	4	5	6	7	8	9
9. 他的生活素质是否很低（例如物质享受）	0	1	2	3	4	5	6	7	8	9
10. 他是否欠缺聪明才智和处事能力	0	1	2	3	4	5	6	7	8	9
11. 他成长的经历是否和常人不同（例如他被养大的方式）	0	1	2	3	4	5	6	7	8	9
12. 他是否经常接触大众广播媒介（例如经常看电视或报章杂志）	0	1	2	3	4	5	6	7	8	9
13. 他是否曾经与一些患有同样问题的人相处过	0	1	2	3	4	5	6	7	8	9
14. 他周围的社会风气是否容许这问题存在	0	1	2	3	4	5	6	7	8	9
15. 他的工作环境是否欠佳	0	1	2	3	4	5	6	7	8	9
16. 他是否受到很沉重的工作压力	0	1	2	3	4	5	6	7	8	9
17. 他身体的健康状况和抵抗能力是否不良	0	1	2	3	4	5	6	7	8	9
18. 他是否受到鬼神的滋扰	0	1	2	3	4	5	6	7	8	9
19. 他是否和家人相处不融洽	0	1	2	3	4	5	6	7	8	9
20. 他是否和同学・朋友或同事相处不融洽	0	1	2	3	4	5	6	7	8	9
21. 他是否缺之意志能力（他不是一个坚强的人）	0	1	2	3	4	5	6	7	8	9

22.他的居住环境是否欠佳	0	1	2	3	4	5	6	7	8	9
23.他是否受到细菌或病毒的感染	0	1	2	3	4	5	6	7	8	9
24.他是否缺之正式的学校教育	0	1	2	3	4	5	6	7	8	9
25.他的生活习惯是否和常人不同（例如他的起居饮食和嗜好）	0	1	2	3	4	5	6	7	8	9
26.他是否缺之宗教信仰	0	1	2	3	4	5	6	7	8	9

您如果认为还有其它的因素能导致一个人患上这问题，请在此写出：

_____

_____

_____

以下是对于一个人能否克服这问题可能是重要的因素。

因素：	完全不重要（没有效用）									非常重要（十分有致）
1. 这个人自己付出了多少努力	0	1	2	3	4	5	6	7	8	9
2. 他有多少意志能力（内在的力量）	0	1	2	3	4	5	6	7	8	9
3. 他有多幸运	0	1	2	3	4	5	6	7	8	9
4. 他有否得到专业性的帮助	0	1	2	3	4	5	6	7	8	9
5. 他一般的克服困难的能力	0	1	2	3	4	5	6	7	8	9
6. 他对这问题有多少资料	0	1	2	3	4	5	6	7	8	9
7. 这问题是否有另一潜伏更深的问题所引发的征状	0	1	2	3	4	5	6	7	8	9
8. 他是否相信能够除去这问题	0	1	2	3	4	5	6	7	8	9
9. 他对于患上这问题感到有多少尴尬	0	1	2	3	4	5	6	7	8	9
10. 这问题对于他所感受到的自我价值和自尊做成多大的损害	0	1	2	3	4	5	6	7	8	9
11. 除去这问题之后会否取悦其他人	0	1	2	3	4	5	6	7	8	9
12. 他有否避开能够导致这问题恶化的情境	0	1	2	3	4	5	6	7	8	9
13. 他对于这问题背后的导因有多少认识	0	1	2	3	4	5	6	7	8	9
14. 他有多少自我控制的能力	0	1	2	3	4	5	6	7	8	9
15. 他有否获得其他人的帮助（他的朋友和所爱的人）	0	1	2	3	4	5	6	7	8	9
16. 他的智能有多高	0	1	2	3	4	5	6	7	8	9
17. 他对神有多少信仰	0	1	2	3	4	5	6	7	8	9
18. 他有否避开患有类似问题的人	0	1	2	3	4	5	6	7	8	9
19. 他的脑部或神经系统是否连作失常	0	1	2	3	4	5	6	7	8	9
20. 他的父母或其中一人是否也患有类似的问题	0	1	2	3	4	5	6	7	8	9
21. 他是否找到受过训练的医疗/心里的专业人士	0	1	2	3	4	5	6	7	8	9
22. 他实际上有多少渴望去复原	0	1	2	3	4	5	6	7	8	9

23. 他有否参加其他为帮助患有同样问题的人而设的社团组织	0	1	2	3	4	5	6	7	8	9
24. 他有多少勇气去改变他的生活方式	0	1	2	3	4	5	6	7	8	9
25. 他对于精神打击自动复原的能力	0	1	2	3	4	5	6	7	8	9
26. 他有否参加一些宗教活动（例如到教堂祈祷，请相士看相或者改变风水）	0	1	2	3	4	5	6	7	8	9
27. 他能够获得朋友，同学或同事多少精神上的支持	0	1	2	3	4	5	6	7	8	9
28. 他有否改变和大众传播媒介的接触的频密程度	0	1	2	3	4	5	6	7	8	9
29. 他的身体对于疾病自动复原的能力	0	1	2	3	4	5	6	7	8	9
30. 他的工作环境得到多少改善	0	1	2	3	4	5	6	7	8	9
31. 他的生活质素能够提高多少（物质享受）	0	1	2	3	4	5	6	7	8	9
32. 他所受的工作压力减少了多少	0	1	2	3	4	5	6	7	8	9
33. 他曾接受过多少正式的学校教育	0	1	2	3	4	5	6	7	8	9
34. 他会否因为这问题而受到法律的惩罚	0	1	2	3	4	5	6	7	8	9
35. 他能够获得多少家人在精神上的支持	0	1	2	3	4	5	6	7	8	9
36. 他的居住环境得到多少改善	0	1	2	3	4	5	6	7	8	9

您如果认为还有其它的因素能帮助克服这问题请在此写出。

_____

_____

_____

APPENDIX C

Expert Judges' Questionnaire

Dear participant,

Your participation in this study is being solicited to assist the researcher in rating causal and curative factors which form the primary stimulus materials for a larger study on Chinese lay beliefs about psychological problems. The ratings you are being asked to provide will form the basis for categorisation of the causal and curative factors along the three dimensions of Weiner's (1980) attributional framework. This will facilitate the analysis of the data from the larger study in terms of Weiner's theory which constitutes the foundation for this study.

Weiner hypothesised that most causal factors could be categorised in terms of three fundamental dimensions: 1) Internal/External; 2) Controllable/Uncontrollable; 3) Stable/Unstable. The Internal/External dimension refers to the idea that a particular causal factor can be seen to be an inherent characteristic of the individual, or as a feature of the environment. The Controllable/Uncontrollable dimension refers to the degree or possibility that the particular causal factor is under the voluntary control of the individual. Finally, the Stable/Unstable dimension reflects the degree to which the particular causal factor is subject to change.

To give an example, suppose that an individual fails an exam. In trying to understand the reason for this failure one might examine a number of causal factors: 1) The ability (or intelligence) of the test taker; 2) The effort exerted by the individual during the exam.; 3) The difficulty of the exam. The ability of the individual can be categorised as internal, uncontrollable and stable, since it is a inherent characteristic of the individual that is not under her or his voluntary control and does not change significantly across different situations. On the other hand, the effort exerted by the test taker can be classified as internal controllable and unstable, since effort is exerted by the individual (from within), is under her or his control and can vary significantly across situations. Finally, the difficulty of the exam can be classified as external, uncontrollable and stable, since it is a function of the person who composed the exam (not the test taker) and is, therefore, not under her or his direct control and it does not vary significantly (given a single form of the exam) across different situations.

With these concepts in mind, please use the five point scale to rate the causal and curative factors presented on the following pages. Using the Internal/External dimension as an example:

Definitely Internal	More Internal than External	Cannot Define	More External than Internal	Definitely External
1	2	3	4	5

The following are the causal factors you are being asked to rate:

1. The problem is caused by the person's genetic disposition.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

2. The law does not proscribe the problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

3. The person lacks social prestige and high status.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

4. The person lacks correct information about the problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

5. The problem is caused by some other deep-rooted problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

6. The person is unlucky or predestined to have the problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

7. Traditional background approves the existence of the problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

8. There is something wrong with the person's brain or nervous system.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

9. His/her quality of life is low (e.g., material life).

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

10. S/he lacks the intelligence or ability to manage things.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

11. His/her past experience (e.g., upbringing) is different from that of normal people.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

12. S/he has very frequent contact with the mass media (e.g., watching TV or reading periodicals).

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

13. The person has had interaction with people having the same problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

14. The surrounding culture approves the existence of the problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

15. The environment in which s/he works/studies is not good.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

16. S/he has been suffering from a very heavy workload.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

17. His/her state of health and resistance of the body to germs is not good.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

18. The person is disturbed by supernatural beings.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

19. S/he is not getting along well with her/his family.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

20. S/he is not getting along well with her/his friends and/or colleagues.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

21. The person lacks willpower (i.e., s/he is not a tough person).

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

22. The environment in which the person lives is not good.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

23. S/he is infected by bacteria or germs.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

24. S/he lacks formal education.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

25. His/her lifestyle is different from that of a normal person (e.g., eating habits, sleeping habits, any peculiar habits).

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

26. S/he lacks religious beliefs.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

The following are the curative factors you are asked to rate:

1. How hard the person tries.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

2. How much willpower (inner strength) the person has.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

3. How lucky the person is.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

4. Whether the person gets professional help.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

5. The person's general ability to overcome problems.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

6. How much information the person has about the problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

7. Whether the problem is a symptom of some other deep-rooted problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

8. Whether the person believes it is possible to eliminate the problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

9. How embarrassed the person feels about having the problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

10. How damaging the problem is to the person's feelings of self worth or self esteem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

11. How much eliminating the problem would please others.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

12. How much a person stays away from situations that make the problem worse.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

13. How much the person understands about the underlying reasons for the problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

14. How much self-control the person has.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

15. Whether the person gets help from other people (friends and loved ones).

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

16. How intelligent the person is.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

17. How much the person believes in God.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

18. How much the person stays away from people with similar problems.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

19. Whether there is something wrong with the person's brain or nervous system.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

20. Whether the person's mother and/or father have a similar problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

21. Whether the person seeks out trained medical/psychological professionals.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

22. How much the person really wants to get better.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

23. Whether the person joins other self help groups for this problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

24. How much courage a person has to change his/her lifestyle.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

25. How much power of recovering from psychological disturbances the person has.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

26. Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller).

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

27. How much psychological support the person can get from friends or colleagues.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

28. Whether s/he has changed the frequency of contact with the mass media.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

29. How much power to recover from diseases the person's body has.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

30. How much the environment in which the person works/studies has been improved.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

31. How much his/her life quality can be improved (i.e., material life).

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

32. How much the workload the person suffered can be reduced.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

33. How much formal education in school the person has had.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

34. Whether the person would be punished by the laws because of this problem.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

35. How much psychological support the person can get from family.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

36. How much the environment in which the person lives has been improved.

Internal	More I than E	Cannot Define	More E than I	External
1	2	3	4	5
Controllable	More C than U	Cannot Define	More U than C	Uncontrollable
1	2	3	4	5
Stable	More S than U	Cannot Define	More U than S	Unstable
1	2	3	4	5

APPENDIX D

Tables of Expert Judges' Mean Ratings for the Attributions of Causes and Cures

Table 2: Expert Judges' Mean Ratings for the 26 Cause Attributions[1]

Attribution:	I/E	C/U	S/U
1. The problem is caused by the person's genetic disposition.	1.20	4.80	1.40
2. The law does not proscribe the problem.	4.60	4.00	1.80
3. The person lacks social prestige and high status.	4.20	3.00	2.20
4. The person lacks correct information about the problem.	3.00	1.80	3.80
5. The problem is caused by some other deep-rooted problem.	3.40	3.80	3.20
6. The person is unlucky or predestined to have the problem.	2.80	4.00	2.80
7. Traditional background approves the existence of the problem.	4.60	4.40	1.60
8. There is something wrong with the person's brain or nervous system.	1.00	4.60	1.60
9. His/her quality of life is low (e.g., material life).	4.40	3.20	2.80
10. S/he lacks the intelligence or ability to manage things.	1.60	4.40	1.60
11. His/her past experience (e.g., upbringing) is different from that of normal people.	4.00	3.60	2.20
12. S/he has very frequent contact with the mass media (e.g., watching TV or reading periodicals).	4.20	1.60	3.40
13. The person has had interaction with people having the same problem.	4.40	2.40	4.00
14. The surrounding culture approves the existence of the problem.	4.80	4.60	1.40
15. The environment in which s/he works/studies is not good.	4.60	2.60	3.80
16. S/he has been suffering from a very heavy workload.	4.40	2.80	3.80
17. His/her state of health and resistance of the body to germs is not good.	1.40	3.00	3.40
18. The person is disturbed by supernatural beings.	2.40	3.40	4.20
19. S/he is not getting along well with her/his family.	3.80	2.40	3.00
20. S/he is not getting along well with her/his friends and/or colleagues.	3.80	2.40	3.40
21. The person lacks willpower (i.e., s/he is not a tough person).	2.00	3.40	2.80
22. The environment in which the person lives is not good.	4.60	3.20	3.60
23. S/he is infected by bacteria or germs.	3.80	3.40	3.60
24. S/he lacks formal education.	3.80	2.20	3.00
25. His/her lifestyle is different from that of a normal person (e.g., eating habits, sleeping habits, any peculiar habits).	2.40	2.00	3.00
26. S/he lacks religious beliefs.	2.80	2.00	2.00

Note: I/E = Locus dimension; C/U = Controllability dimension; S/U = Stability dimension.

[1]Ratings equal to or below 2 indicate that the particular attribution is considered either Internal, Controllable or Stable. Ratings equal to or above 4 indicate that the particular attribution is considered either External, Uncontrollable or Unstable.

Table 3: Expert Judges' Mean Ratings for the 36 Cure Attributions[1]

Attribution:	I/E	C/U	S/U
1. How hard the person tries.	2.20	2.00	3.40
2. How much willpower (inner strength) the person has.	1.80	2.20	2.00
3. How lucky the person is.	4.00	4.40	4.00
4. Whether the person gets professional help.	4.00	1.60	3.40
5. The person's general ability to overcome problems.	1.80	2.60	3.00
6. How much information the person has about the problem.	3.60	2.60	3.60
7. Whether the problem is a symptom of some other deep-rooted problem.	3.00	3.80	3.00
8. Whether the person believes it is possible to eliminate the problem.	1.60	2.00	3.00
9. How embarrassed the person feels about having the problem.	1.80	3.20	4.00
10. How damaging the problem is to the person's feelings of self worth or self esteem.	2.80	3.80	3.20
11. How much eliminating the problem would please others.	4.50	4.25	3.25
12. How much a person stays away from situations that make the problem worse.	2.00	1.60	4.00
13. How much the person understands about the underlying reasons for the problem.	3.00	2.40	3.80
14. How much self-control the person has.	2.00	3.00	2.40
15. Whether the person gets help from other people (friends and loved ones).	4.20	2.20	3.80
16. How intelligent the person is.	1.60	4.60	1.40
17. How much the person believes in God.	2.20	2.00	2.00
18. How much the person stays away from people with similar problems.	3.80	1.60	4.00
19. Whether there is something wrong with the person's brain or nervous system.	1.40	4.40	1.80
20. Whether the person's mother and/or father have a similar problem.	4.00	4.40	1.80
21. Whether the person seeks out trained medical/psychological professionals.	3.80	1.80	3.60
22. How much the person really wants to get better.	2.40	2.60	3.20
23. Whether the person joins other self help groups for this problem.	4.00	2.00	3.80
24. How much courage a person has to change his/her lifestyle.	2.20	2.00	3.40
25. How much power of recovering from psychological disturbances the person has.	3.20	3.40	2.80
26. Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller).	3.80	1.80	3.40
27. How much psychological support the person can get from friends or colleagues.	4.60	3.80	4.20
28. Whether s/he has changed the frequency of contact with the mass media.	4.00	1.60	3.60
29. How much power to recover from diseases the person's body has.	2.60	3.40	2.80

Note: I/E = Locus dimension; C/U = Controllability dimension; S/U = Stability dimension.

[1]Ratings equal to or below 2 indicate that the particular attribution is considered either Internal, Controllable or Stable. Ratings equal to or above 4 indicate that the particular attribution is considered either External, Uncontrollable or Unstable.

Table 3: (cont.) Expert Judges' Mean Ratings for the 36 Cure Attributions[1]

Attribution:	I/E	C/U	S/U
30. How much the environment in which the person works/studies has been improved.	4.20	4.00	4.40
31. How much his/her life quality can be improved (i.e., material life).	4.00	2.60	3.40
32. How much the workload the person suffered can be reduced.	4.20	2.60	3.60
33. How much formal education in school the person has had.	4.00	3.00	2.80
34. Whether the person would be punished by the laws because of this problem.	4.60	4.40	1.80
35. How much psychological support the person can get from family.	4.40	3.80	3.40
36. How much the environment in which the person lives has been improved.	4.60	4.00	3.60

Note: I/E = Locus dimension; C/U = Controllability dimension; S/U = Stability dimension.

[1]Ratings equal to or below 2 indicate that the particular attribution is considered either Internal, Controllable or Stable. Ratings equal to or above 4 indicate that the particular attribution is considered either External, Uncontrollable or Unstable.

APPENDIX E

Tables of Subjects' Mean Ratings for the 26 Attributions of Cause

Table 4: Mean Ratings for the 26 Cause Attributions for All Problems and Categories of Problems[1]

Attribution	ALL	Antisocial	Adult P.	Child P.
1. The problem is caused by the person's genetic disposition.	4.77	2.37	6.08	5.87
2. The law does not proscribe the problem.	2.66	5.15	1.01	1.88
3. The person lacks social prestige and high status.	2.92	3.97	2.83	2.00
4. The person lacks correct information about the problem.	4.74	6.05	4.00	4.16
5. The problem is caused by some other deep-rooted problem.	4.93	4.96	5.06	4.77
6. The person is unlucky or predestined to have the problem.	1.89	1.86	1.88	1.94
7. Traditional background approves the existence of the problem.	4.01	4.42	3.44	4.16
8. There is something wrong with the person's brain or nervous system.	3.88	2.63	4.63	4.41
9. His/her quality of life is low.	3.68	4.00	3.23	3.82
10. S/he lacks the intelligence or ability to manage things.	3.72	3.47	3.16	4.54
11. His/her past experience is different from that of normal people.	5.29	5.30	4.75	5.81
12. S/he has very frequent contact with the mass media.	4.13	4.41	3.67	4.31
13. The person has had interaction with people having the same problem.	4.31	5.55	3.05	4.35
14. The surrounding culture approves the existence of the problem.	4.48	6.50	2.69	4.23
15. The environment in which s/he works/studies is not good.	4.08	4.62	4.19	3.43
16. S/he has been suffering from a very heavy workload.	4.29	3.84	5.67	3.42
17. His/her state of health and resistance of the body to germs is not good.	4.04	2.58	5.66	3.91
18. The person is disturbed by supernatural beings.	1.41	1.17	2.02	1.04
19. S/he is not getting along well with her/his family.	4.45	3.67	4.68	5.00
20. S/he is not getting along well with her/his friends and/or colleagues.	4.34	3.62	4.67	4.74
21. The person lacks willpower	4.71	4.07	5.13	4.95
22. The environment in which the person lives is not good.	3.95	3.62	4.13	4.12
23. S/he is infected by bacteria or germs.	2.56	1.42	3.73	2.51
24. S/he lacks formal education.	3.95	4.23	3.07	4.53
25. His/her lifestyle is different from that of a normal person	4.03	3.35	4.57	4.16
26. S/he lacks religious beliefs.	2.69	3.38	2.23	2.45

Note: ALL = Combined ratings for all problems; Antisocial = Ratings for all Antisocial behaviour problems; Adult P. = Ratings for all Adult pathological problems; Child P. = Ratings for all Child pathological problems.

[1]Values below 2.31 = Unimportant; Values above 5.37 = Important.

Table 5: Mean Ratings for the 26 Cause Attributions for Antisocial Behavioural problems[1]

Attribution	OA	CG	CA	SA	UBD	LCR
1. The problem is caused by the person's genetic disposition.	2.37	1.77	3.67	3.05	2.09	1.22
2. The law does not proscribe the problem.	5.15	5.33	6.13	1.67	6.62	5.82
3. The person lacks social prestige and high status.	3.97	3.19	4.29	3.25	4.71	4.33
4. The person lacks correct information about the problem.	6.05	5.77	6.04	6.29	5.30	6.74
5. The problem is caused by some other deep-rooted problem.	4.96	5.23	5.71	4.30	5.74	3.76
6. The person is unlucky or predestined to have the problem.	1.86	2.36	1.91	2.43	1.47	1.13
7. Traditional background approves the existence of the problem.	4.42	3.14	5.18	4.00	5.48	4.30
8. There is something wrong with the person's brain or nervous system.	2.63	2.41	4.29	2.00	1.91	2.36
9. His/her quality of life is low.	4.00	2.90	4.87	3.48	4.41	4.13
10. S/he lacks the intelligence or ability to manage things.	3.47	3.63	4.04	3.90	3.41	2.39
11. His/her past experience is different from that of normal people.	5.30	3.68	7.04	5.38	4.64	5.61
12. S/he has very frequent contact with the mass media.	4.41	3.95	4.35	3.62	5.00	5.09
13. The person has had interaction with people having the same problem.	5.55	6.45	5.22	4.67	6.50	4.86
14. The surrounding culture approves the existence of the problem.	6.50	5.73	6.70	5.14	7.73	7.09
15. The environment in which s/he works/studies is not good.	4.62	4.68	4.52	3.62	5.18	5.10
16. S/he has been suffering from a very heavy workload.	3.84	3.36	5.08	3.48	4.71	2.52
17. His/her state of health and resistance of the body to germs is not good.	2.58	1.91	4.04	2.81	2.14	1.91
18. The person is disturbed by supernatural beings.	1.17	1.14	1.71	1.14	1.09	.74
19. S/he is not getting along well with her/his family.	3.67	3.73	5.48	4.86	2.14	2.17
20. S/he is not getting along well with her/his friends and/or colleagues.	3.62	3.00	5.38	4.90	2.50	2.26
21. The person lacks willpower	4.07	6.73	3.79	3.33	3.45	3.09
22. The environment in which the person lives is not good.	3.62	2.91	4.54	2.48	3.18	4.83
23. S/he is infected by bacteria or germs.	1.42	.75	1.58	1.10	.82	2.70
24. S/he lacks formal education.	4.23	3.38	5.63	2.67	3.77	5.43
25. His/her lifestyle is different from that of a normal person	3.35	2.64	3.88	3.48	1.95	4.77
26. S/he lacks religious beliefs.	3.38	3.59	4.04	2.71	3.45	3.04

Note: OA = Overall ratings for category; CG = Compulsive Gambling; CA = Child Abuse; SA = Social Apathy; UBD = Using the Back Door (Corruption); LCR = Lack of Civic Responsibility.

[1]Values below 2.31 = Unimportant; Values above 5.37 = Important.

Table 6: Mean Ratings for the 26 Cause Attributions for Adult pathological problems[1]

Attribution	OA	SHK	NEU	AGO	AN	SCZ
1. The problem is caused by the person's genetic disposition.	6.08	6.23	6.13	5.52	4.95	7.43
2. The law does not proscribe the problem.	1.01	1.23	.38	.62	1.75	1.17
3. The person lacks social prestige and high status.	2.83	2.45	2.67	3.38	3.10	2.61
4. The person lacks correct information about the problem.	4.00	4.00	3.83	4.38	5.48	2.48
5. The problem is caused by some other deep-rooted problem.	5.06	4.77	5.13	4.48	5.35	5.59
6. The person is unlucky or predestined to have the problem.	1.88	1.82	1.62	1.80	2.05	2.14
7. Traditional background approves the existence of the problem.	3.44	2.73	3.29	4.05	3.81	3.43
8. There is something wrong with the person's brain or nervous system.	4.63	2.85	4.50	3.86	5.29	6.43
9. His/her quality of life is low.	3.23	3.82	3.08	2.86	3.48	2.91
10. S/he lacks the intelligence or ability to manage things.	3.16	2.32	3.61	3.76	3.00	3.09
11. His/her past experience is different from that of normal people.	4.75	2.95	4.22	5.90	5.10	5.65
12. S/he has very frequent contact with the mass media.	3.67	2.36	3.38	5.05	3.71	3.91
13. The person has had interaction with people having the same problem.	3.05	2.55	2.75	3.86	4.00	2.26
14. The surrounding culture approves the existence of the problem.	2.69	2.41	2.04	2.67	3.67	2.74
15. The environment in which s/he works/studies is not good.	4.19	3.41	5.58	3.81	3.95	4.05
16. S/he has been suffering from a very heavy workload.	5.67	4.71	7.42	4.52	5.00	6.43
17. His/her state of health and resistance of the body to germs is not good.	5.66	5.95	6.48	4.38	5.90	5.52
18. The person is disturbed by supernatural beings.	2.02	1.18	2.79	2.05	1.57	2.39
19. S/he is not getting along well with her/his family.	4.68	3.68	5.79	4.33	4.33	5.09
20. S/he is not getting along well with her/his friends and/or colleagues.	4.67	3.27	5.88	4.67	4.43	4.96
21. The person lacks willpower	5.13	3.59	5.63	5.57	5.76	5.09
22. The environment in which the person lives is not good.	4.13	4.24	4.54	4.33	3.81	3.70
23. S/he is infected by bacteria or germs.	3.73	5.64	3.29	1.86	5.38	2.57
24. S/he lacks formal education.	3.07	2.32	2.54	3.62	3.24	3.70
25. His/her lifestyle is different from that of a normal person	4.57	3.95	4.29	4.71	6.00	4.00
26. S/he lacks religious beliefs.	2.23	1.27	3.21	2.24	2.24	2.09

Note: OA = Overall ratings for category; SHK = Shen-Kuei Syndrome; NEU = Neurasthenia; AGO = Agoraphobia; AN = Anorexia Nervosa; SCZ = Schizophrenia.

[1]Values below 2.31 = Unimportant; Values above 5.37 = Important.

Table 7: Mean Ratings for the 26 Cause Attributions for Childhood Pathological Problems[1]

Attribution	OA	MR	AUT	ADH	CD	LD
1. The problem is caused by the person's genetic disposition.	5.87	7.82	6.29	5.52	4.64	5.04
2. The law does not proscribe the problem.	1.88	1.86	.83	1.10	4.91	.78
3. The person lacks social prestige and high status.	2.00	1.59	2.50	.90	3.24	1.73
4. The person lacks correct information about the problem.	4.16	3.15	3.33	3.14	5.95	5.14
5. The problem is caused by some other deep-rooted problem.	4.77	4.62	4.91	4.14	5.50	4.65
6. The person is unlucky or predestined to have the problem.	1.94	1.81	2.48	1.67	2.05	1.73
7. Traditional background approves the existence of the problem.	4.16	4.40	3.71	4.10	4.50	4.14
8. There is something wrong with the person's brain or nervous system.	4.41	4.62	4.78	4.55	4.73	3.43
9. His/her quality of life is low.	3.82	3.82	3.83	2.90	5.41	3.00
10. S/he lacks the intelligence or ability to manage things.	4.54	5.14	4.29	3.14	4.55	5.57
11. His/her past experience is different from that of normal people.	5.81	5.59	6.58	4.38	7.36	5.04
12. S/he has very frequent contact with the mass media.	4.31	4.14	4.04	3.52	4.95	4.87
13. The person has had interaction with people having the same problem.	4.35	3.18	3.42	4.20	7.05	4.00
14. The surrounding culture approves the existence of the problem.	4.23	3.32	3.46	2.95	6.45	4.87
15. The environment in which s/he works/studies is not good.	3.43	3.00	4.00	2.25	3.50	4.22
16. S/he has been suffering from a very heavy workload.	3.42	3.36	3.92	2.57	3.10	4.04
17. His/her state of health and resistance of the body to germs is not good.	3.91	5.36	3.61	3.48	2.23	4.83
18. The person is disturbed by supernatural beings.	1.04	1.14	1.54	1.14	.59	.78
19. S/he is not getting along well with her/his family.	5.00	3.68	5.42	3.19	7.05	5.52
20. S/he is not getting along well with her/his friends and/or colleagues.	4.74	3.59	5.58	3.43	6.23	4.74
21. The person lacks willpower	4.95	3.86	4.13	4.71	6.52	5.61
22. The environment in which the person lives is not good.	4.12	3.68	3.92	3.05	5.67	4.30
23. S/he is infected by bacteria or germs.	2.51	4.09	1.92	2.19	1.86	2.52
24. S/he lacks formal education.	4.53	4.36	3.33	4.38	6.09	4.57
25. His/her lifestyle is different from that of a normal person	4.16	2.91	4.88	3.90	5.33	3.78
26. S/he lacks religious beliefs.	2.45	2.18	2.63	2.05	3.73	1.65

Note: OA = Overall ratings for category; MR = Mental Retardation; AUT = Autistic Disorder; ADH = Attention-Deficit Hyperactivity Disorder; CD = Conduct Disorder; LD = Learning Disability.
[1]Values below 2.31 = Unimportant; Values above 5.37 = Important.

APPENDIX F

Tables of Subjects' Mean Ratings for the 36 Attributions of Cures

Table 8: Mean Ratings for the 36 Cure Attributions for All Problems and Categories of Problems[1]

Attribution	ALL	Antisocial	Adult P.	Child P.
1. How hard the person tries.	6.48	6.82	6.08	6.55
2. How much willpower (inner strength) the person has.	6.52	6.55	6.39	6.64
3. How lucky the person is.	3.31	2.68	3.55	3.74
4. Whether the person gets professional help.	5.69	4.67	6.31	6.15
5. The person's general ability to overcome problems.	5.66	5.30	5.70	6.01
6. How much information the person has about the problem.	4.41	4.10	4.86	4.26
7. Whether the problem is a symptom of some other deep-rooted problem.	5.02	4.93	5.27	4.84
8. Whether the person believes it is possible to eliminate the problem.	5.81	5.65	6.03	5.76
9. How embarrassed the person feels about having the problem.	4.83	4.91	4.52	5.07
10. How damaging the problem is to the person's feelings of self worth or self esteem.	5.38	5.57	4.94	5.66
11. How much eliminating the problem would please others.	4.50	4.63	4.05	4.86
12. How much a person stays away from situations that make the problem worse.	5.38	5.05	5.63	5.47
13. How much the person understands about the underlying reasons for the problem.	5.70	5.76	5.79	5.53
14. How much self-control the person has.	6.30	6.34	6.34	6.20
15. Whether the person gets help from other people (friends and loved ones).	6.41	6.06	6.65	6.53
16. How intelligent the person is.	3.63	3.26	3.25	4.47
17. How much the person believes in God.	2.66	2.95	2.50	2.54
18. How much the person stays away from people with similar problems.	3.67	4.09	2.95	3.99
19. Whether there is something wrong with the person's brain or nervous system.	3.47	2.55	3.72	4.21
20. Whether the person's mother and/or father have a similar problem.	4.83	4.43	4.99	5.08
21. Whether the person seeks out trained medical/psychological professionals.	5.27	4.00	6.24	5.62
22. How much the person really wants to get better.	6.19	5.95	6.30	6.33
23. Whether the person joins other self help groups for this problem.	4.85	4.64	5.13	4.76

Note: ALL = Combined ratings for all problems; Antisocial = Ratings for all Antisocial behaviour problems; Adult P. = Ratings for all Adult pathological problems; Child P. = Ratings for all Child pathological problems.

[1]Values below 3.64 = Unimportant; Values above 6.26 = Important.

Table 8: (cont.) Mean Ratings for the 36 Cure Attributions for All Problems and Categories of Problems[1]

Attribution	ALL	Antisocial	Adult P.	Child P.
24. How much courage a person has to change his/her lifestyle.	6.28	6.36	6.24	6.25
25. How much power of recovering from psychological disturbances the person has.	5.76	5.27	6.31	5.69
26. Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller).	3.14	3.48	2.95	2.96
27. How much psychological support the person can get from friends or colleagues.	5.83	5.41	5.66	6.48
28. Whether s/he has changed the frequency of contact with the mass media.	4.44	4.36	4.29	4.70
29. How much power to recover from diseases the person's body has.	4.70	3.65	5.38	5.13
30. How much the environment in which the person works/studies has been improved.	4.85	4.48	5.14	4.95
31. How much his/her life quality can be improved (i.e., material life).	4.57	4.33	4.70	4.70
32. How much the workload the person suffered can be reduced.	4.85	4.21	5.46	4.88
33. How much formal education in school the person has had.	4.57	4.75	4.04	4.96
34. Whether the person would be punished by the laws because of this problem.	3.51	5.39	1.94	3.18
35. How much psychological support the person can get from family.	6.20	5.47	6.23	6.97
36. How much the environment in which the person lives has been improved.	4.69	4.31	4.84	4.94

Note: ALL = Combined ratings for all problems; Antisocial = Ratings for all Antisocial behaviour problems; Adult P. = Ratings for all Adult pathological problems; Child P. = Ratings for all Child pathological problems.

[1]Values below 3.64 = Unimportant; Values above 6.26 = Important.

Table 9: Mean Ratings for the 36 Cure Attributions for Antisocial Behaviour Problems[1]

Attribution	OA	CG	CA	SA	UBD	LCR
1. How hard the person tries.	6.82	6.86	7.04	6.86	6.18	7.13
2. How much willpower (inner strength) the person has.	6.55	7.05	6.88	6.05	6.09	6.61
3. How lucky the person is.	2.68	2.67	2.70	2.62	3.19	2.26
4. Whether the person gets professional help.	4.67	4.41	6.58	4.24	3.82	4.13
5. The person's general ability to overcome problems.	5.30	5.45	6.04	5.10	5.00	4.83
6. How much information the person has about the problem.	4.10	3.77	4.50	4.24	4.50	3.48
7. Whether the problem is a symptom of some other deep-rooted problem.	4.93	5.41	5.96	4.14	5.05	4.00
8. Whether the person believes it is possible to eliminate the problem.	5.65	5.86	5.96	5.48	5.36	5.55
9. How embarrassed the person feels about having the problem.	4.91	4.29	5.46	4.33	4.73	5.61
10. How damaging the problem is to the person's feelings of self worth or self esteem.	5.57	5.50	5.67	4.62	5.41	6.57
11. How much eliminating the problem would please others.	4.63	4.38	4.30	4.52	4.86	5.04
12. How much a person stays away from situations that make the problem worse.	5.05	5.50	5.43	4.14	5.95	4.22
13. How much the person understands about the underlying reasons for the problem.	5.76	6.05	6.68	5.43	5.77	4.91
14. How much self-control the person has.	6.34	6.55	7.42	5.70	5.82	6.09
15. Whether the person gets help from other people (friends and loved ones).	6.06	6.00	6.75	6.55	5.55	5.48
16. How intelligent the person is.	3.26	3.29	4.12	3.10	3.00	2.74
17. How much the person believes in God.	2.95	4.09	3.41	1.48	2.68	3.00
18. How much the person stays away from people with similar problems.	4.09	4.68	4.57	3.14	4.18	3.83
19. Whether there is something wrong with the person's brain or nervous system.	2.55	1.52	4.00	1.67	2.09	3.22
20. Whether the person's mother and/or father have a similar problem.	4.43	4.15	6.17	5.10	2.23	4.35
21. Whether the person seeks out trained medical/psychological professionals.	4.00	3.38	6.67	2.90	2.82	3.87
22. How much the person really wants to get better.	5.95	5.55	7.17	5.48	5.59	5.83
23. Whether the person joins other self help groups for this problem.	4.64	4.55	5.58	4.86	3.41	4.74

Note: OA = Overall ratings for category; CG = Compulsive Gambling; CA = Child Abuse; SA = Social Apathy; UBD = Using the Back Door (Corruption); LCR = Lack of Civic Responsibility.

[1]Values below 3.64 = Unimportant; Values above 6.26 = Important.

Table 9: (cont.) Mean Ratings for the 36 Cure Attributions for Antisocial Behaviour Problems[1]

Attribution	OA	CG	CA	SA	UBD	LCR
24. How much courage a person has to change his/her lifestyle.	6.36	6.73	6.92	6.24	5.64	6.22
25. How much power of recovering from psychological disturbances the person has.	5.27	5.14	6.09	4.81	4.57	5.65
26. Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller).	3.48	3.59	4.08	2.62	3.41	3.61
27. How much psychological support the person can get from friends or colleagues.	5.41	5.59	5.87	5.52	4.86	5.17
28. Whether s/he has changed the frequency of contact with the mass media.	4.36	4.23	4.54	4.10	4.38	4.52
29. How much power to recover from diseases the person's body has.	3.65	3.00	4.39	3.62	3.48	3.70
30. How much the environment in which the person works/studies has been improved.	4.48	3.76	5.13	3.90	5.27	4.22
31. How much his/her life quality can be improved (i.e., material life).	4.33	3.86	4.58	3.65	4.77	4.70
32. How much the workload the person suffered can be reduced.	4.21	3.73	5.25	3.74	4.64	3.57
33. How much formal education in school the person has had.	4.75	3.91	5.21	4.26	4.59	5.61
34. Whether the person would be punished by the laws because of this problem.	5.39	5.18	6.39	2.35	6.67	6.04
35. How much psychological support the person can get from family.	5.47	5.95	6.50	4.05	5.24	5.39
36. How much the environment in which the person lives has been improved.	4.31	4.14	4.96	3.10	4.62	4.57

Note: OA = Overall ratings for category; CG = Compulsive Gambling; CA = Child Abuse; SA = Social Apathy; UBD = Using the Back Door (Corruption); LCR = Lack of Civic Responsibility.
[1]Values below 3.64 = Unimportant; Values above 6.26 = Important.

Table 10: Mean Ratings for the 36 Cure Attributions for Adult pathological problems[1]

Attribution	OA	SHK	NEU	AGO	AN	SCZ
1. How hard the person tries.	6.08	6.36	6.00	6.33	6.67	5.13
2. How much willpower (inner strength) the person has.	6.39	6.23	6.65	6.76	6.76	5.61
3. How lucky the person is.	3.55	3.64	4.50	3.52	2.40	3.48
4. Whether the person gets professional help.	6.31	6.41	6.50	5.81	5.81	6.95
5. The person's general ability to overcome problems.	5.70	5.41	5.83	5.95	5.81	5.52
6. How much information the person has about the problem.	4.86	5.71	4.48	5.29	5.24	3.74
7. Whether the problem is a symptom of some other deep-rooted problem.	5.27	5.14	5.48	4.71	5.48	5.52
8. Whether the person believes it is possible to eliminate the problem.	6.03	5.95	6.00	6.29	6.95	5.04
9. How embarrassed the person feels about having the problem.	4.52	4.55	4.22	5.00	4.86	4.09
10. How damaging the problem is to the person's feelings of self worth or self esteem.	4.94	5.10	4.83	5.67	4.81	4.35
11. How much eliminating the problem would please others.	4.05	4.50	2.95	5.05	4.00	3.78
12. How much a person stays away from situations that make the problem worse.	5.63	5.09	5.86	5.40	5.86	5.91
13. How much the person understands about the underlying reasons for the problem.	5.79	5.68	6.17	6.52	6.14	4.52
14. How much self-control the person has.	6.34	5.43	6.65	6.50	6.95	6.17
15. Whether the person gets help from other people (friends and loved ones).	6.65	6.67	6.12	6.00	6.86	7.61
16. How intelligent the person is.	3.25	3.05	3.04	4.71	2.57	2.91
17. How much the person believes in God.	2.50	2.23	3.33	2.29	1.95	2.59
18. How much the person stays away from people with similar problems.	2.95	2.09	3.08	3.62	3.85	2.22
19. Whether there is something wrong with the person's brain or nervous system.	3.72	1.57	4.48	3.24	3.81	5.30
20. Whether the person's mother and/or father have a similar problem.	4.99	4.50	4.92	4.57	4.38	6.48
21. Whether the person seeks out trained medical/psychological professionals.	6.24	5.95	6.78	5.45	5.86	7.00
22. How much the person really wants to get better.	6.30	5.73	6.83	5.90	7.24	5.77
23. Whether the person joins other self help groups for this problem.	5.13	5.09	5.04	5.19	5.10	5.22

Note: OA = Overall ratings for category; SHK = Shen-Kuei Syndrome; NEU = Neurasthenia; AGO = Agoraphobia; AN = Anorexia Nervosa; SCZ = Schizophrenia.

[1]Values below 3.64 = Unimportant; Values above 6.26 = Important.

Table 10: (cont.) Mean Ratings for the 36 Cure Attributions for Adult pathological problems[1]

Attribution	OA	SHK	NEU	AGO	AN	SCZ
24. How much courage a person has to change his/her lifestyle.	6.24	6.00	6.54	6.55	6.43	5.68
25. How much power of recovering from psychological disturbances the person has.	6.31	5.77	6.79	6.20	6.38	6.35
26. Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller).	2.95	2.77	3.58	2.48	2.81	3.04
27. How much psychological support the person can get from friends or colleagues.	5.66	5.14	5.92	5.76	5.14	6.26
28. Whether s/he has changed the frequency of contact with the mass media.	4.29	3.77	4.22	5.05	4.14	4.30
29. How much power to recover from diseases the person's body has.	5.38	5.41	5.33	4.48	5.52	6.14
30. How much the environment in which the person works/studies has been improved.	5.14	4.86	6.13	4.55	4.76	5.22
31. How much his/her life quality can be improved (i.e., material life).	4.70	4.91	4.79	4.76	5.10	3.95
32. How much the workload the person suffered can be reduced.	5.46	5.23	6.30	4.95	5.33	5.41
33. How much formal education in school the person has had.	4.04	3.45	3.25	5.05	4.80	3.83
34. Whether the person would be punished by the laws because of this problem.	1.94	2.19	1.70	2.00	2.76	1.09
35. How much psychological support the person can get from family.	6.23	6.50	6.13	6.00	5.86	6.61
36. How much the environment in which the person lives has been improved.	4.84	4.82	4.79	4.90	4.52	5.13

Note: OA = Overall ratings for category; SHK = Shen-Kuei Syndrome; NEU = Neurasthenia; AGO = Agoraphobia; AN = Anorexia Nervosa; SCZ = Schizophrenia.

[1]Values below 3.64 = Unimportant; Values above 6.26 = Important.

Table 11: Mean Ratings for the 36 Cure Attributions for Childhood Pathological Problems[1]

Attribution	OA	MR	AUT	ADH	CD	LD
1. How hard the person tries.	6.55	6.05	5.38	5.64	7.09	8.17
2. How much willpower (inner strength) the person has.	6.64	6.45	5.67	5.64	7.14	7.83
3. How lucky the person is.	3.74	3.50	4.71	3.27	3.27	3.64
4. Whether the person gets professional help.	6.15	6.33	6.12	6.00	5.82	6.41
5. The person's general ability to overcome problems.	6.01	6.41	4.96	5.10	6.32	6.83
6. How much information the person has about the problem.	4.26	4.14	3.43	4.36	4.64	4.78
7. Whether the problem is a symptom of some other deep-rooted problem.	4.84	4.50	4.88	3.64	5.41	5.17
8. Whether the person believes it is possible to eliminate the problem.	5.76	6.32	5.17	4.64	5.86	6.32
9. How embarrassed the person feels about having the problem.	5.07	4.29	4.29	4.55	6.14	5.91
10. How damaging the problem is to the person's feelings of self worth or self esteem.	5.66	5.48	4.83	4.18	6.77	6.35
11. How much eliminating the problem would please others.	4.86	4.55	3.91	4.55	5.67	5.55
12. How much a person stays away from situations that make the problem worse.	5.47	5.23	5.43	4.50	6.41	5.27
13. How much the person understands about the underlying reasons for the problem.	5.53	5.23	5.13	5.09	6.41	5.61
14. How much self-control the person has.	6.20	6.09	5.04	5.73	7.09	6.87
15. Whether the person gets help from other people (friends and loved ones).	6.53	6.62	6.21	4.55	6.91	7.39
16. How intelligent the person is.	4.47	5.36	3.83	2.80	4.32	5.13
17. How much the person believes in God.	2.54	2.45	3.00	1.00	3.36	2.09
18. How much the person stays away from people with similar problems.	3.99	3.10	3.63	3.27	6.00	3.55
19. Whether there is something wrong with the person's brain or nervous system.	4.21	5.18	4.29	4.27	3.64	3.68
20. Whether the person's mother and/or father have a similar problem.	5.08	5.73	6.25	4.64	5.14	3.32
21. Whether the person seeks out trained medical/psychological professionals.	5.62	6.36	6.04	6.09	5.36	4.48
22. How much the person really wants to get better.	6.33	6.32	6.13	5.00	7.36	6.22
23. Whether the person joins other self help groups for this problem.	4.76	4.73	5.63	3.18	5.59	3.87

Note: OA = Overall ratings for category; MR = Mental Retardation; AUT = Autistic Disorder; ADH = Attention-Deficit Hyperactivity Disorder; CD = Conduct Disorder; LD = Learning Disability.
[1]Values below 3.64 = Unimportant; Values above 6.26 = Important.

Table 11: (cont.) Mean Ratings for the 36 Cure Attributions for Childhood Pathological Problems[1]

Attribution	OA	MR	AUT	ADH	CD	LD
24. How much courage a person has to change his/her lifestyle.	6.25	5.91	6.08	4.55	7.41	6.43
25. How much power of recovering from psychological disturbances the person has.	5.69	5.82	5.79	4.18	6.18	5.70
26. Whether the person has participated in certain religious rites (e.g., worship in a Temple, pray in a church, or ask for advice from a fortune teller).	2.96	2.41	3.54	2.64	3.59	2.43
27. How much psychological support the person can get from friends or colleagues.	6.48	6.64	6.46	5.73	6.55	6.65
28. Whether s/he has changed the frequency of contact with the mass media.	4.70	4.27	5.83	4.09	4.68	4.22
29. How much power to recover from diseases the person's body has.	5.13	4.95	5.71	3.91	5.23	5.18
30. How much the environment in which the person works/studies has been improved.	4.95	5.24	5.00	4.27	4.86	5.04
31. How much his/her life quality can be improved (i.e., material life).	4.70	4.68	4.71	4.18	5.23	4.43
32. How much the workload the person suffered can be reduced.	4.88	4.64	5.13	4.70	4.64	5.17
33. How much formal education in school the person has had.	4.96	5.00	4.21	4.18	5.71	5.39
34. Whether the person would be punished by the laws because of this problem.	3.18	3.32	2.13	1.55	6.25	2.26
35. How much psychological support the person can get from family.	6.97	7.14	6.96	5.64	7.24	7.22
36. How much the environment in which the person lives has been improved.	4.94	5.00	5.21	3.91	5.50	4.57

Note: OA = Overall ratings for category; MR = Mental Retardation; AUT = Autistic Disorder; ADH = Attention-Deficit Hyperactivity Disorder; CD = Conduct Disorder; LD = Learning Disability.
[1]Values below 3.64 = Unimportant; Values above 6.26 = Important.

APPENDIX G

Ethics Review and Copyright approval

March 2, 1994

From: Department of Educational Psychology
Research and Ethics Committee

The Research and Ethics Committee of the Department of Educational Psychology has reviewed the attached proposal and finds it acceptable with respect to ethical matters.

Applicants: Dr. H. Janzen on behalf of David Sinclair (graduate student).

Title: Chinese Lay Beliefs About Mental Disorder: An Examination of Mainland Chinese Ideas About Aetiology and Cure.

Participating Agency(ies):

Recommended Change:

p.p. [signature]
Chairman or Designate, Research and Ethics Committee

March 2/94
Date

Department of Educational Psychology Ethics Review
Description of Project and Procedures for Observing Ethical Guidelines

PLEASE PROVIDE 2 COPIES OF THIS DOCUMENT TO THE CHAIR, RESEARCH COMMITTEE, DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

Project Title: Chinese Lay Beliefs About Mental Disorder: An Examination of Mainland Chinese ideas about aetiology and cure.

Project Deadlines:

Date by which project approval is desired: February, 1994

Starting Date: Feb., 1994 **Ending Date:** Apr., 1994

Applicant(s):

Principal Investigator: David Sinclair

University Status: Current MEd. student

University Address: 6-102 Education North

University Telephone: 5245/3746

If the principal investigator is a student, please provide the following information:

If the research project is for a thesis or dissertation, has the applicant's Supervisory Committee approved the project? Yes: X **No:** ____

Name of Academic Advisor (or instructor if a course project)

Dr. H. Janzen (for Dr. B. Bain)

University Address: 1-145E Education North

University Telephone: 5718

		Feb.11,1994
Signature of Principal Investigator. In case of a graduate student, signature of faculty advisor.	**Signature of Graduate Student(if applicable)**	**Date**

Please describe the specific procedures to be used in observing ethical guidelines for research involving human participants. References to the SSHRC Guidelines for research using human subjects are cited below. Researchers should also familiarize themselves with the more detailed discussion in Annex H of the Social Sciences and Humanities Research Council of Canada, *Research Grants: Guide for Applicants.* Some granting agencies adopt SSHRC guidelines, others have different guidelines that researchers must follow in making grant applications.

Statement of Research Problem and Methods:
(Attach copies of instruments, including tests, interview guides, observational forms, or sample items/questions. In the case of well-known instruments, names only need to be provided.)

The project is designed to evaluate the beliefs of lay (i.e., individuals with no training in the mental health field) people from mainland China regarding causal and curative factors in mental disorder. The results will be compared with those from a previous study by Luk and Bond (1992) of which the current study is a replication and extension.

Participants will complete a questionnaire on which they will rate 26 factors relating to causes, and 36 factors relating to cures of a given mental disorder. Each subject will be asked to provide their series of ratings for three separate disorders with each causal and curative factor being rated on a 10 point Likert scale. Within the scales for each disorder, respondents will also be asked to provide any additional comments they may wish to include regarding causal or curative factors for the given disorder. The questionnaires are slightly modified versions of those used by Luk and Bond (see appendix). The questionnaires will be distributed for respondents to complete at their own convenience, and returned to the researcher by prepaid post.

Who are the participants and how will they be involved in your research?

The subjects for the study will all be adult volunteers recruited from the membership of the CSSA (Chinese Students and Scholars Association) at the university of Alberta. Participation involves provision of some basic background information on the cover sheet, completing the rating scales and additional comments sections and mailing the completed questionnaire (see appendix).

How will the nature and purpose of the research be explained to participants?

"Certain individual or collective 'rights' must be maintained. These include the right to know the precise nature and purpose of the research, so that consent may be given or withheld advisedly. . . ." (#8, p.27)

The cover letter includes a brief description of the research and some of the perceived benefits of the project (see appendix).

How will informed consent of participants be obtained?

"Informed consent should be obtained in writing. Where this is not practical, the procedures used in obtaining consent should be on record."(#14, p.28)

"Written consent should set out: a) purpose of the research; b) benefits envisaged; c) any inconveniences; d) tasks to be performed; e) rights of the subject, *e.g.* the right to withdraw without penalty, the right to confidentiality of personal information; f) risks involved; g) the name(s) of the person(s), group(s) or institution(s) eliciting or receiving the consent." (#15, p.28)

Please attach copies of all consent forms to be used.

(see appendix)

Are children, captive or dependent populations used? __x__ No ____ Yes. If so, detail how consent will be obtained.

"Informed consent of parents or guardian and, where practical, of children should be obtained in research involving children. . . ."(#12, p.28)

" 'Captive and dependent populations' are individuals or groups in a relationship where a power differential could operate to their disadvantage as subjects: for example, students, minors, prisoners, employees, military personnel, incapacitiated people and the socially deprived. . . . In addition to consent of the subjects themselves, informed consent of the authorities should be obtained. . . . Captive subjects should always have the right and power to veto others' consent. (Intro. and #33, p.29)

Please attach copies of all consent to be used.

How will provision be made for exercising the right to opt out at any time?
"Participants should understand that they may withdraw at any time, just as investigators may terminate their research in the interest of the subjects, the project or themselves." (#11, p.28)
Instructions are included in the covering letter (see appendix).

How will confidentiality and anonymity be maintained?
"There should be a clear understanding between the investigator and subjects as to what extent information they divulge will be kept confidential in the original use of data and their deposit for future use. . . . Unless there is an explicit statement by the researcher to the contrary, to which the subject agrees, personal information given by the subject will be confidential and the researcher will explain steps to be taken to ensure confidentiality and anonymity." (#28,29, p.29)
(see appendix)

Is deception and/or risk involved in the project? _X_ No ____ Yes. If so, how will the interests of the subjects be protected?
"Deception is a situation in which subjects have essential information withheld and/or are intentionally misled about procedures and purposes. . . .[and should only be used when] . . . a) significant advance could result; and b) no other methodology would suffice. . . Deception should never be permitted when there is risk of harm to the subject or when it is not possible to advise subjects subsequently as to the reasons why the deception was necessary." (Intro.,#18, 17, p. 28)
"The onus is on the researcher to avoid or minimize risks to subjects both in carrying out the research and in publication of results. . . . Except where there is clear foreseeable benefit to the participant, such as in therapeutic research, the researcher has no right to attempt to make long-term changes in a person's behavior or attitudes." (#23, 21, p.28)

Are there any other procedures relevant to your observation of the ethical guidelines that are not described above? If so, please describe them and discuss how you intend to ensure that no ethical problems develop.

UNIVERSITY OF CALIFORNIA, LOS ANGELES UCLA

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DEPARTMENT OF PSYCHOLOGY
405 HILGARD AVENUE
LOS ANGELES, CALIFORNIA 90024-1563

Sept. 6, 1994

Mr. David Sinclair
6-102 Education North
University of Alberta
Edmonton, Alberta
Canada T6G-2G5

Dear Mr. Sinclair:

You have my permission to reproduce Table 2, page 7, from my 1979 article entitled A Theory of Motivation for Some Classroom Experiences (Journal of Educational Psychology) and Figure 2, page 565, from my 1985 article entitled An Attributional Theory of Achievement-Related Motivation and Emotion (Psychological Review).

Sincerely,

Bernard Weiner
Professor

BW:kn